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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI

FEBRUARY, 1948

NO. 2

PNEUMOCOCCIC LOBAR PNEUMONIA

A Review of Cases in Rhode Island Hospital, 1945-1947

ROBERT V. LEWIS, M.D.

The Author, Robert V. Lewis, M.D., of Providence. Haffewreffer Research Fellow in Medicine, Rhode Island Hospital.

Introduction

Lobar Pneumonia has been the subject of extensive and intensive reviews in the past. Many of the factors which affect the natural history of the disease have been minimized in importance by the use of the effective therapeutic agents now at hand. This report is an attempt to re-evaluate, under the present regime of treatment, those factors in the disease which were so important in the past. The factors considered are the type organism, the character of the patient, the white cell response, the time of onset of therapy, and the types and amounts of therapy. The older reviews of pneumonia, especially that of Reimann¹ and the still older reviews typified by that of Norris², have been used for comparison. Patients arriving at Rhode Island Hospital are often neglected patients. Many represent therapeutic failures. These considerations should not be overlooked when viewing the following statistics.

Method

All cases of Lobar Pneumonia admitted to the Rhode Island Hospital between 1 January 1945 and 1 February 1947 were included in this review, except when a causative organism other than pneumococcus was isolated. There were only twelve cases, in over two hundred studied, which fell into the latter classification. Those cases where pneumonia was made as a second diagnosis were included in the series, but omitted from sections of the report where the effect of the first diagnosis would be such as to obscure the true nature of the pneumonia.

Results

MATERIAL:

One hundred and ninety-seven patients are included in the study. Approximately 75% of these are adults and the remainder children. The breakdown of the total group is shown in Table No. 1.

SEX AND AGE INCIDENCE:

Seventy per cent of all Lobar Pneumonia seen in Rhode Island Hospital, during the period stud-

Breakdown of Cases

ADULTS

Uncomplicated	93
With Pleural Effusion	11
With Suspected Pleural Effusion (Undiagnosed)	12
Empyema	2
Pneumococcic Meningitis	1
Pneumonia as Second Diagnosis	17
Dead 24 Hours	10
Dead 24 Hours Plus	8

154

CHILDREN

Uncomplicated	41
With Pleural Effusion	0
With Suspected Pleural Effusion (Undiagnosed)	1
Empyema	0
Pneumonia as Second Diagnosis	0
Dead 24 Hours	1
Dead 24 Hours Plus	0

43

197

TABLE I

continued on next page

ied, occurred in males. Throughout the literature this sex ratio appears with constancy.^{1,2,3} In the old literature it was generally considered that this sex incidence was due to the greater exposure of men than woman.² Reimann¹ makes the observation which is confirmed by this report that such reasoning does not explain the constancy of this ratio during the first year of age. The percentage of males in the pneumonia cases under one year of age in Rhode Island Hospital during 1945-6, was 75% compared with the 70% average for all ages.

LOBES INVOLVED:

The frequency with which each of the five lobes of the lungs is involved in Lobar Pneumonia in this Rhode Island Hospital series, reveals the following order: left lower lobe, right upper lobe, right lower lobe, left upper lobe, right midlobe. The same order held for children. The right lung was involved one and one-half times as often as the left. Twelve per cent of the cases observed had two or more lobes involved. The order of incidence of lobes involved in this series agrees with larger series except in one instance. In this Rhode Island Hospital series, the right upper lobe takes precedence of the right lower lobe, whereas the reverse is seen more often according to the literature.¹

ORGANISMS ISOLATED:

The identification of organisms has become of less importance and more difficult since the advent of antibiotics. Of the two hundred cases admitted, pneumococci were identified in fifty. In 40% of the fifty cases in which organisms were isolated, the identification was not carried beyond the four typing mixtures. This was due to lack of type specific typing serum. In general the types observed in this series compare with the types observed in the literature. Type 1, which is most frequently encountered and usually accounts for about 27% of all pneumonia, occurred in 24% of the cases typed.

WHITE COUNT:

It is agreed that the leukocyte count is elevated in the early course of Lobar Pneumonia. It is a clinical impression that low white counts have a bad prognosis, although there are marked individual differences. Some observations on the behavior of white counts have been made in this series of cases. In those cases where afebrilia occurred in the second and third day, no cases with a white count below 12,000 were encountered, only one case in twenty of these cases had a white count below 14,000. By contrast three cases out of sixteen total cases in the next higher group with four days

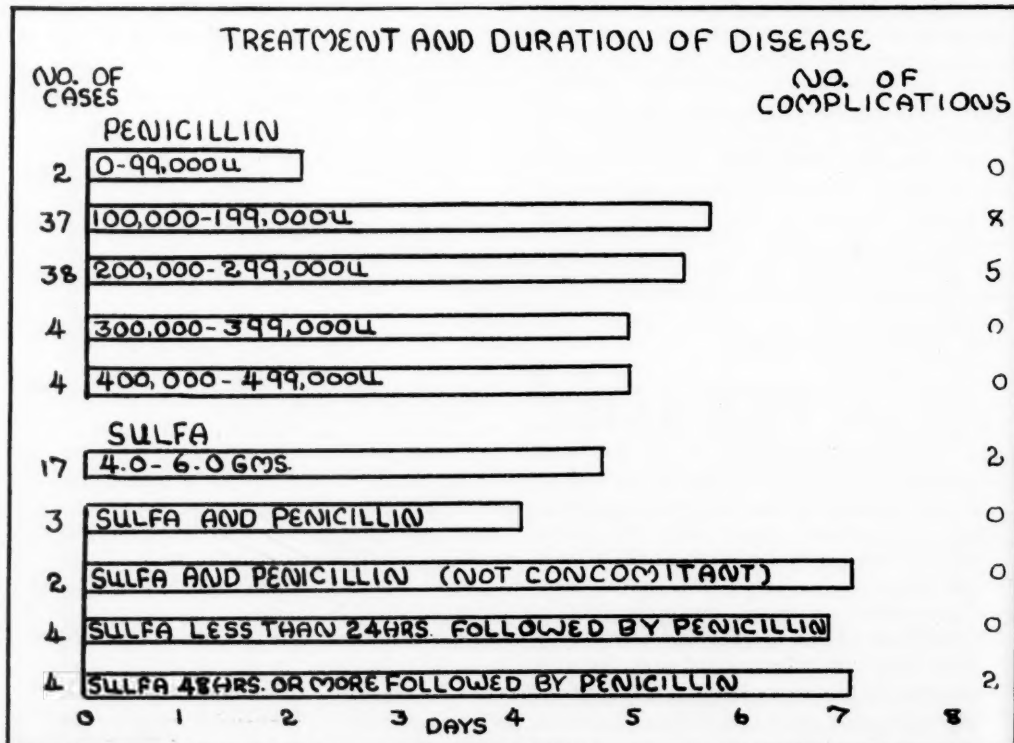


FIGURE 1

hospitalization, showed a white count below 10,000. Those cases with a 2-5 day hospitalization in contrast to patients with a 6-9 day hospitalization showed a higher initial white count which dropped sharply and rapidly following treatment. The same behavior of the white count was noted in the children's series.

TREATMENT:

Penicillin became increasingly more available to the civilian population in Providence during '45 and '46. The majority of cases were treated by penicillin in varying dosages. A not insignificant number were treated by sulfa drugs alone. A compilation of the data pertinent to treatment is listed on Table No. 2 and graphically portrayed in Figure No. 1. The results in children and adults appear comparable in all respects. There appears to be very little difference between those patients treated with 1-200,000 units per day and those treated with 2-300,000. The differences shown by those treated with less than 100,000 units are probably due to the mildness of the disease and early therapy in those two cases. In the eight cases treated with over 300,000 units per day, the average number of days to afebrilia is less. The absence of any complication whatsoever in this group is worthy of much attention. The sensitivity of the pneumococcus IN VITRO is usually much less than 0.5 units per c.c. Such a concentration is obtained IN VIVO by 500,000 units of penicillin intramus-

cularly per day. This then is the theoretical maximum daily dosage required. That lesser dosages are effective as seen in this study indicates that the pneumococcus is usually much more sensitive and requires less than the maximal. This is confirmed by IN VITRO studies.

In comparing the effects of sulfa drugs alone with penicillin it is seen that sulfa compares well with penicillin except for complications of the disease. The danger of sulfonamides, especially in the elderly patients, has been stressed by Burgess, Wing, Kramer, and Bowman.³

In those cases where penicillin and sulfa were used together the results need explanation. Where penicillin and sulfa were both used adequately and simultaneously from the start excellent results were obtained, the number of days hospitalized were few and complications absent. In the other cases where penicillin and sulfa were not used simultaneously there is the factor of unsuccessful therapy requiring a shift from one drug to the other.

In general high doses of penicillin, that is, over 300,000 units of penicillin and sulfa in adequate doses, given simultaneously, all other factors being equal are the best treatments in that the hospitalization is short and complications are minimal.

LENGTH OF TREATMENT:

In this series the absence of fever finally and permanently was taken as the criteria of cure. In considering the distribution of cases to twenty-four hours afebrilia it is noted that the mode occurred in five days. Hospitalization to afebrilia without complication occurred between 2-9 days. In most cases over nine days there was complication or a suspicion of the same. Norris, in 1913, collected a series of approximately 2,000 cases and described the duration of Lobar Pneumonia, Reimann, in 1938, did the same with 873 untreated cases. Penicillin and sulfa have reduced the natural duration of the disease between two and three days.

DELAY IN TREATMENT:

It is a truism to state that delays in treatment in medicine affect the course of disease. The mode of the uncomplicated cases occurs with a two-day history of the disease prior to hospitalization and treatment. The average number of days prior to admission in uncomplicated cases is $3\frac{1}{2}$ days. Contrasting this with those cases in which complications occurred, the mode occurred on the seventh day and the bulk of cases were admitted after the fourth day of disease. There is overlapping in both groups. Many cases admitted after the fourth day of disease may represent therapeutic failures by local physicians. Nevertheless, the fact remains, that considering hospital admissions only,

continued on next page

Treatment Effects

(ADULTS ONLY)

A. PENICILLIN (ALONE)

Per	Diem	# Cases	Ave. # Days # to Afebrilia	Complications*
0 —	99,000.....	2	2	0
100,000 —	199,000.....	37	$5\frac{3}{4}$	8
200,000 —	299,000.....	38	$5\frac{1}{2}$	5
300,000 —	399,000.....	4	5	0
400,000 —	499,000.....	4	5	0

B. SULFA (ALONE)

4.0 — 6.0 grams.....	17	$4\frac{3}{4}$	2
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C. PENICILLIN AND SULFA

Both Adequate			
Concomitantly	3	4	0
75% of Treatment Sulfa			
25% Penicillin	2	7	0
Sulfa Less Than 24			
Hours After Admission.....	4	$6\frac{3}{4}$	0
Sulfa 48 Hours Followed by Penicillin	4	7	2

* Complications include empyema, pleural effusion, poor resolution, death after 72 hours hospitalization.

TABLE 2

the patient who reveals a history of three or under three days' duration has a much better outlook than a patient who gives a history in excess of $3\frac{1}{2}$ days. The antibiotic cannot overcome the disadvantage placed upon it by the delay in its early institution. The length of history prior to admission affects the probabilities of complications, and the number of days of required therapy. (Table No. 3, Fig. No. 2) After the fourth day further delay more markedly affects the subsequent course of the disease. The stage of gray hepatization occurs about the fifth day and data indicate that antibiotics administered after the fourth day may have difficulty in reaching the organisms because of decreased blood supply to the area. M. Cutts, Gormly, and Burgess⁴ demonstrated the same unfavorable effect of delay in treatment in relation to serum and sulfapyridine therapy. There is one factor in the nature of the disease which must not be overlooked in considering the effect of delay in treatment on the course of disease. This is the observation of Norris in 1913, namely, that the nature of the onset affects markedly the outcome of the disease. That is, those cases which have an abrupt beginning have an early and successful outcome. It seems reasonable, therefore, to consider that the severity of the initial attack will determine the promptness with which the patient consults his physician. When the attack is severe, which in itself promises a good outcome, the patient is seen early and receives early therapy.

Treatment Delay and Disease Duration

No. of Hospital Days to Afebrilia		Average No. of Days to Admission	No. of Cases
2	Uncomplicated	2 ($1\frac{1}{3}$)	2
3	"	3 ($2\frac{1}{4}$)	15
4	"	3	17
5	"	3 ($2\frac{1}{6}$)	17
6	"	3	14
7	"	4 ($3\frac{1}{3}$)	13
8	"	4	7
9	"	4	3
14	Pleural Effusion	5	11
14	Suspected Pleural Effusion	5	12
30	Empyema	8	2

TABLE 3

SUMMARY AND CONCLUSIONS:

1. The constants which have been observed in the past in Lobar Pneumonia were again observed in this review. Namely, an incidence of seven males to three females, progressive increase in morbidity in ascending age groups, the Winter and Spring seasonal incidence, more frequent involvement of the right lung, and the preponderance of types 1-3 pneumococci as causative organisms.
2. The length of the disease and complications are directly related to the duration of the disease prior to treatment.
3. Penicillin and the sulfa drugs have reduced the duration of the natural history of Lobar Pneumonia.

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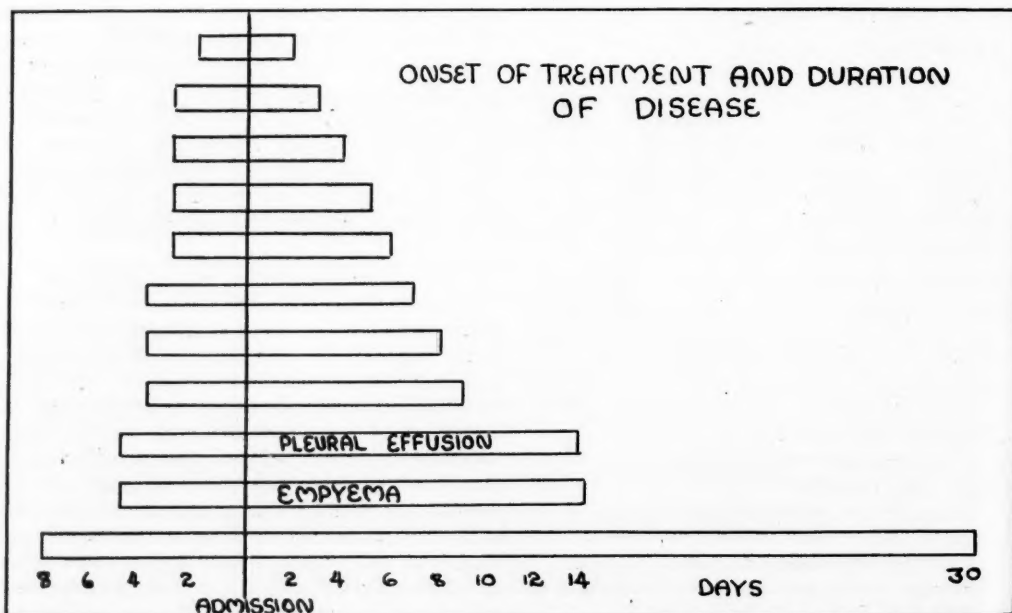


FIGURE 2

CHOLESTEROL TOLERANCE

FREDERIC J. BURNS, M.D.

The Author: *Frederic J. Burns, M.D., Visiting Physician, St. Joseph's Hospital, Providence.*

THE RECOGNITION of cholesterol deposits in the coronary arteries has long been known and, in recent times, has been widely investigated. In fact, various forms of investigations are being attempted. Primarily, this paper will try to show the possibility of an individual tolerance to cholesterol intake. Before such a theory can be accepted, however, a very extensive and comprehensive study of the entire problem must be completed. Much has been done, to date, but finality is lacking and may be long in coming.

The difficulties in estimating the cholesterol in the blood are such that a routine laboratory test will not give satisfactory and consistent results. It is most important that one of the accepted methods be used. In the cases reported in this study, a modification of the Bloor's test was employed throughout, and always the work was done by the same laboratory worker.

It is now generally accepted that the usual findings in those who have a coronary occlusion is an elevated cholesterol. This condition is noted even in individuals who present no other factors that would *per se* raise the cholesterol level. It has been observed, also, that the abnormal cholesterol can be lowered by diet. Substantial confirmation of this fact has recently been made by authorities in medical centers where this problem holds much interest. This process of reduction of the cholesterol by diet is a relatively slow one, but it is effective. In Figure No. 1 five such cases are shown, two of which were reported in a previous paper. All of these individuals, as others, on a similar diet, do not complain severely about food restriction. These patients, too, have received no medication. Diet alone has produced the desired effect. Two other patients with decreased metabolic rates, with high cholesterol, and with clinical findings of hypo-thyroidism showed a noticeable decrease in their levels when the diet was used in conjunction with oral thyroid extract.

This tendency towards a lowering in the cholesterol level as a result of dieting is now meeting with a more widespread acceptance among those

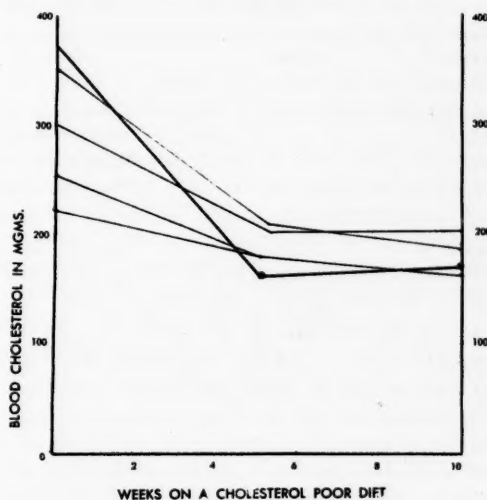


FIGURE 1

doing like investigations. Moreover, it has led to a whole series of unanswered questions.

One problem with great clinical importance which has developed from this study is the possibility of effecting a disappearance of the atheromata by a lowering of the blood cholesterol. From the microscopic pictures of atheromata, it does not now seem that such a result is attainable. In fact, the very nature of their composition seems to make a reabsorption practically impossible. A personal experience with two patients out of a group gives some credence to this opinion. These two persons had successfully lowered their elevated blood cholesterol, one for twelve weeks, the other for fifteen weeks, when death suddenly occurred from coronary thrombosis. This was at a time when neither of them had been under any undue strain. One had experienced an occlusion previously, while the second had diabetes that for many months had been under adequate control by diet and insulin. Possibly the period of twelve or fifteen weeks was not sufficient time to decrease the deposited cholesterol. But it is more probable that, once deposited, it cannot be eliminated. On this question, however, further

continued on next page

investigations must be accomplished before anything definite can be stated.

Another problem of tremendous importance is that of personal intolerance of cholesterol intake. This paper is but an initial attempt to show that individual factors must be considered in the specific case. Ten carefully selected patients were used to estimate tolerance and the findings give some indication of the part that this particular phase of the problem may play in the prophylactic approach in the treatment of some vascular diseases. These ten individuals were selected because no physical abnormalities were present. Of special interest was the exclusion of anyone with even the slightest suggestion of glandular disturbance, while persons with excess fatty tissue were considered unsuitable. The reason for omitting this latter group becomes clear when it is realized that with adiposity there is a general tendency for an elevation of the cholesterol. The age group of these ten varied from eighteen to fifty-four years with a predominance in the early forties. The main factor determining the choice of each one was the excessively high cholesterol intake, and on each a fasting blood cholesterol was done. When the possibility of lowering the cholesterol by diet is accepted, it seems quite reasonable that ten such individuals on a high cholesterol diet would reveal elevations. As seen in Figure No. 2, however, only one of these showed any increase. Of course, ten is much too small a number from which to obtain a percentage estimation, but it appears to the writer that the majority of this group have demonstrated some form of tolerance to cholesterol intake. At the moment, I have no suggestion that this tolerance, if it be such, is related to excretion, or to endocrine activity.

Accepting the theory that cholesterol is directly related to some coronary artery diseases, then an explanation should be made of the instances noted in the literature of coronary occlusion without an

elevation of blood cholesterol having been reported. At present, no explanation is available. Yet the usual report, in recent date, is one of an increase in cholesterol following a coronary thrombosis. In view of this result serious consideration of all factors is necessary before definite information can be assured.

Since elevated cholesterol can be lowered by diet, it seems feasible that the nine cases which did not show an elevation, while consuming much cholesterol daily, have demonstrated a tolerance towards it. This leads to the possibility that a condition, as yet undefined, may exist wherein the individual handles cholesterol poorly and this condition, in turn, causes atheromata to form. An analogy might be drawn with the diabetic, or the gouty individual, in whom the inability to handle sugars and purine-derivative-producing foods can be demonstrated by the test on their fasting blood. The effects of this intolerance is shown in the pathological findings both in diabetes and in gout. To me, it seems more than a coincidence that elevated blood cholesterol is found in the patients with atheromata which contain cholesterol in good quantity.

If the same proven principle and pattern successfully used in diabetes and gout is now applied to this particular problem, then it does not seem unreasonable to state that the intolerance itself is responsible for elevated blood cholesterol, which encourages atheromata formation. As yet, the findings do not warrant complete affirmation of such a view and one naturally proceeds cautiously. Certainly, a new avenue of investigation, one of determining intolerance, is evident and appears worthy of wide consideration.

Conclusion:

From the review of the literature and from extensive personal investigation, I believe two conclusions can be entertained in this early stage of inquiry.

(a) Since cholesterol appears more and more related to some vascular changes, it will be of real value to estimate the individual's cholesterol tolerance early in life. If this tolerance is lacking then the patient should be guided by a cholesterol poor diet in an attempt to maintain a normal blood level.

(b) The microscopic picture of the atheromata and the instances of the two deaths cited above, indicate the possibility that atheromata, once formed, can not be decreased by the lowering of the blood cholesterol level.

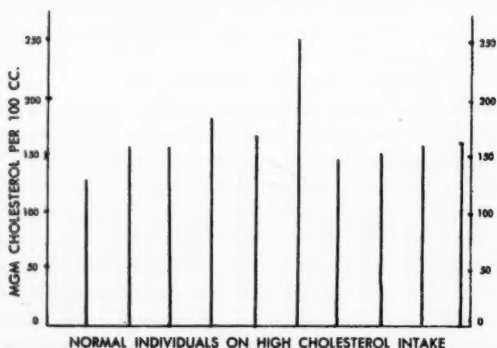


FIGURE II

WILMS TUMOR*

Report of Two Cases in the Same Family

MIHRAN A. CHAPIAN, M.D.

The Author. *Mihran A. Chapien, M.D., Chief, Urological Service, The Memorial Hospital, Pawtucket, R. I.*

WILMS tumor is the most common malignant abdominal tumor found in children. It is rare in the adult. It has an extremely high mortality rate and affects the male and the female alike. It is found with equal frequency in the right and left kidney. Histologically, Wilms tumor is an embryonal mixed tumor, usually adeno-myosarcoma, but its pathogenesis is still unsettled. It is radiosensitive. There is no proof that trauma or infectious diseases have any bearing on its development. Metastasis to the lymph glands and distant metastases to the lungs and liver are late in the disease.

A painless swelling on one side of the abdomen is the first sign of Wilms tumor in the majority of the cases. Hematuria is relatively uncommon. Diagnosis is made by the presence of a tumor mass and urographic studies.

The following two cases in the same family are of interest and worthy of reporting. Case 1. C. F., male, age 3, normal delivery at full term, was admitted to the pediatric service on March 22, 1944, and seen in consultation by the urological service. The mother stated that the child had been perfectly well until three months ago when she noticed a hard lump on the right side of the abdomen. Shortly after the mass was noted, the child complained of general abdominal pain which lasted several hours. There was no vomiting nor elevation of temperature. One year ago he was knocked down by an automobile but no serious injury resulted. Family history was irrelevant except that the father's grandmother had seven children, 4 boys and 3 girls, and all 4 boys died at about the age of 2 years of unknown cause.

Physical examination revealed a well developed and fairly well nourished but rather pale, 3-year-old male child, not acutely ill. Temperature, pulse and respirations were within normal limits. There was a soft systolic murmur at the apex. There

was a large, non tender, firm mass on the right side of the abdomen extending to the midline and below the crest of the ilium. Genitalia were normal. The urine was essentially negative. Red blood cells were 3,480,000. Hemoglobin 7.5 gms. White blood cells 9800. Blood urea nitrogen 14.5 mgs. Wassermann and Hinton tests were negative.

An intravenous urogram showed a normal left kidney. On the right side there was a large mass extending down to the pelvis. There was no evidence of contrast medium on this side. X-ray examination of the chest was negative.

A diagnosis of Wilms tumor was made and the child received 4 blood transfusions, a total amount of 1000 cc. In the meantime, deep x-ray therapy was started and a total dosage of 1568"r" was given in the course of 15 days. It caused noticeable shrinkage of the tumor but the treatment was discontinued due to severe toxic reactions.

Transperitoneal nephrectomy was carried out on April 26th. The renal pedicle was ligated first and the tumor mass removed. The wound was closed without drainage. The specimen was round and smooth in outline and measured 19x12x10 cm. Microscopic examination revealed scattered areas of muscle tissue with inclusion of glands and a large amount of connective tissue. Only a few distorted glomeruli could be recognized. Pathological diagnosis was Wilms tumor.

Convalescence was uneventful and the wound healed per primum. Immediate postoperative irradiation was thought inadvisable due to severe toxic reaction caused by preoperative treatment, and the patient was discharged on the 29th postoperative day.

The child was seen periodically by Dr. Thomas P. Sheridan of the pediatric service and showed progressive improvement. However, when he was brought for x-ray treatment on September 18th, there was evidence of metastasis to the supra-clavicular region and a palpable mass was present at the site of the operation. These lesions almost completely disappeared following irradiation with a total dosage of 1222"r". When seen again 5 weeks later, there was a large gland on the left side of the neck and a large mass occupying the right side of the abdomen. The child rapidly went

continued on next page

* Presented at the John F. Kenney Annual Clinic, at The Memorial Hospital, Pawtucket, on October 29, 1947.

downhill and died on November 17th, six and a half months after the operation.

Case 2. J. F., brother of the previous patient, age 3, normal delivery at full term, was admitted to the pediatric service on June 18, 1945, and seen in consultation by the urological service. The mother stated that the child complained of abdominal pain during the past 24 hours and did not eat well and was constipated for three days. His previous admission was on January 4, 1945. A diagnosis of meningococcus meningitis was made and he was discharged 3 weeks later, fully recovered.

Physical examination revealed a well developed and well nourished but somewhat pale, 3-year-old male child, lying quietly in bed. Temperature was 102, pulse 100 and respirations 22. There was a blowing systolic murmur at the apex. Abdominal palpation revealed a fairly large, non tender, smooth mass in left upper quadrant extending just below the level of the umbilicus. Genitalia were normal. Urine was entirely negative. Red blood cells were 3,830,000, hemoglobin 9.5 grams and white blood cells 19,950. Blood urea nitrogen 8 mgs. A preliminary x-ray film showed a soft tissue mass on the left side of the abdomen. An intravenous urogram showed a normal right kidney. Left pyelogram was essentially negative except that the lower calyx was not well visualized and the upper portion of the left ureter was displaced mesially reaching the midline of the lumbar spine. Retrograde pyelography gave similar results. X-ray examination of the chest was negative. Likewise, barium studies of the gastro-intestinal tract gave negative results.

In view of the above findings, a diagnosis of Wilms tumor was made. Pre-operative x-ray treatment was not given in this case for fear of toxic reaction as experienced in the previous case, and, also, because this was not a very large tumor and no great difficulty was anticipated in its removal.

Transperitoneal nephrectomy was done on July 6th and again the wound was closed without drainage. The specimen measured 12x12x10 cm. On section there was a small area where normal parenchyma could be recognized. There were several cystic areas just beneath the cortex. The remainder of the specimen was made up of a spongy, yellow to grayish white mass. Microscopic examination showed contracted glomeruli, degenerated tubules and a reticulated structure. Pathological diagnosis was Wilms tumor.

Postoperative course was smooth and the incision healed per primum. X-ray treatment was started 14 days after the operation and a total dose of 4123"r" was given in a period of 20 days. At the time of his discharge on August 8th, he looked fairly well and was quite active.

This patient was followed up at the Tumor Clinic. When seen on September 20th, he looked well and no evidence of the disease was noticeable. However, ten days later, a small mass was palpable at the left lower quadrant and the child appeared listless. X-ray treatment was resumed and a total dose of 1504"r" was given in the course of 24 days. On the last day of treatment, no evidence of tumor could be detected. Three weeks later, abdominal examination revealed the presence of ascites indicating metastasis to the liver and the portal system and the child looked cachectic. He was readmitted on November 15th. Paracentesis was done on two occasions and each time about 2000cc of hemorrhagic fluid was obtained. The child lost ground rapidly and expired on December 25th, 5 months and 19 days after the operation. Autopsy was not done.

Seven months ago the parents had a third boy, delivered normally and at full term. This child was examined 12 days ago and found perfectly normal. Intravenous urography, done 3 days later, was entirely negative. It is our intention to examine this child at least every 3 months and carry out urographic studies every 6 to 9 months in order to detect early any evidence of this disease that may be present and try to save him from the fate of his brothers.

Discussion. 1. Familial tendency: In spite of vast amount of literature dealing with Wilms tumor, reports of authentic cases in the same family have been rare. Walker, Strumpell, Deuticke and Bobbio have reported cases occurring in the members of the same family but these were not all proved by operation and tissue examination. However, Maslow, in 1940, reported Wilms tumor occurring in one brother and two sisters, all three proven by operation, and another brother in whom a diagnosis of Wilms tumor was made but operation was deemed inadvisable and autopsy was not done. As far as the writer was able to ascertain, this communication is the second report of Wilms tumor in the same family proved by operation and pathological examination. This report and the previous ones by the above authors seem to indicate a familial tendency to this disease.

2. Treatment: It is generally accepted that nephrectomy and postoperative irradiation are necessary procedures in order to accomplish a cure, if at all possible. However, there is some controversy in regard to preoperative irradiation. Those in favor of it claim that by the shrinkage of the tumor, the operation is rendered easier and the operative mortality and postoperative morbidity are lessened. On the other hand, Ladd and his followers claim that Wilms tumor of any size can be removed by an anterior transperitoneal approach and that the longer the operation is postponed the

continued on page 109

THE PATTERN WAS ESTABLISHED*

GUY W. WELLS, M.D.

The Author. *Guy W. Wells, M.D., of Providence, President of the Providence Medical Association, 1947.*

THE Providence Medical Association will celebrate later in the month its One Hundredth Anniversary with fitting recognition. Plans for the occasion have been under consideration for the past year.

However, without encroaching on the speakers for that meeting, it seems appropriate, even essential, that we pause here tonight to reflect for a few minutes on the past one hundred years of medicine as this Association has experienced it.

The beginning of the nineteenth century is not arbitrarily called the beginning of modern medicine. There are definite reasons, without which medicine would have continued as it had in the past, with here and there the product of a brilliant mind pretty completely buried or limited to small areas near medical colleges. Harvey's *DE MORTU CORDIS* in 1628 is an example; Malpighi's description of the capillary system in 1661 is another. There were many other giants in the earth through the seventeenth and eighteenth centuries but they were isolated and apart from the average mind.

The American and French revolutions freed the minds of mankind in large areas of the world and opened the door to an unlimited horizon. Although the American Colonies had fewer physical resources and establishments at the time, the inhabitants of a young and virile nation do not appear to have been deterred from making their own opportunities and from prosecuting with vigor their own conceptions. Newspapers and early American books give plenty of proof that every citizen enjoyed his right to think. Many and varied were the societies formed for study and interchange of knowledge. These were emergency measures to take the place of physical equipment that already existed in long-settled countries. The inspiration and stimulation must have been great, for America grew in mental stature.

*Presidential Address Before the Providence Medical Association, at Providence, Monday, January 6, 1948.

Europe was naturally the center of learning, and many from the United States studied in European universities. The sciences were advancing rapidly the latter part of the eighteenth and early nineteenth centuries. Mathematics, physics, chemistry, and biology advanced rapidly. Helmholtz announced his theory of Conservation of Energy; Bernard describes the liver function for converting and storing glycogen and states that trauma to the floor of the 4th ventricle produces glycosuria. Darwin's *ORIGIN OF THE SPECIES* did a great deal to clarify biological thinking and to start biology on a firm foundation for rapid progress, that has continued up to the present time.

Medicine, utilizing every branch of science, is dependent on the growth of science for its own development. The brilliant scientific period of the first half of the nineteenth century furnished the necessary foundation for medicine to reap the inevitable benefits, and so it was about the year 1847 and 1848 when the Providence Medical Association, one hundred years ago this month, was formed. At practically the same time were formed the Royal Academy of Sciences in Vienna; the American Association for the Advancement of Sciences; the Societe de Biologie in Paris; the American Medical Association; and the New York Academy of Medicine.

Problems existed in 1848 and were as acute as they are today. The constitution of the Providence Medical Association in 1848 mentions separation of the Regular from the Irregular practitioners, promotion of the character, interests, and honor by maintaining union and harmony in the profession, elevation of the standard of medical education, cultivation and advancement of science by united effort for mutual improvement. Are not these reasons exactly the same that we would give today, after one hundred years?

It is interesting that one of the first important matters discussed and settled was minimum fee tables, and the committee did it in a period of nine days. Do fee schedules sound familiar — all but the nine days? They wasted little time from there on, organization was about completed, delegates to the national convention were elected, one of the original members was summarily dropped

continued on next page

for using the Association's name in a public advertisement. It was regarded as derogatory to the dignity and honor of the Society. A committee was appointed to secure in advance performances of a scientific and practical nature for each monthly meeting. The Association was well on its way to secure for itself the objectives enumerated in the constitution. The programs were formal followed by discussions.

The first year the members gave case reports on diseases of the femur, papers on dysentery, "hooping" cough, and typhoid fever. Specimens of typhoid ulcerations of the large and small bowel were shown at the same time. Etherization in midwifery occupied two successive meetings, and the Association appointed a committee to find room for a medical library.

It is not the intention of this paper to recite the history of the Association, for others will do that later with better effect. This much is necessary for the sake of comparison.

It is interesting to note the purposes of the Association in our recently revised constitution. Again are mentioned the advancement of sound medical science and the promotion of character, interests and honor of the medical fraternity, and harmonious unity of purpose. We have specifically stated other objectives, such as stimulation in activity in civic health and general welfare, and interest in enactment and enforcement of just medical and public health laws. Also we affirm our support of the State Society and of the American Medical Association. The year after the founding of this Association, 1848, three delegates were elected to attend the national convention in Boston. In a short time committees were elected to advise the Mayor on matters of public health and general welfare.

The history of early medical societies reveals that a large number of them sank into oblivion within a short time of their founding. A glance at the constitutions of a few might explain their failure. Most of them had little reference to improvement of medical science or education. Some did not offer a scientific program. There were infrequent references to the honor and integrity of the profession. Some were reorganized, often under a different name. The continuous, progressive growth of the Providence Medical Association is not surprising, when we consider the principles set forth in the constitution by the Founders are more vital to progressive medicine today than in the year of 1848. That is probably the chief reason for its vigorous growth. Men who could think for at least the next one hundred years certainly had a deep bond of interest and could hardly have failed to attract other men of like caliber. They established a pattern for monthly meetings, that has scarcely changed from that first year. Minutes of

the previous meetings were read. Committees assembled facts and made recommendations. The issues were settled by vote, and the scientific part of the program, announced at least one month in advance, got under way. At the annual meeting, officers gave their reports, and all officers were elected for the coming year.

Today the Association has expanded greatly, in numbers and in other fields of interest both to the public and to the medical profession. We now meet in, and have the privileges of the Rhode Island Medical Building and its splendid library. That surely would have pleased Dr. C. W. Parsons. In place of one standing committee there are now twelve, embracing such subjects as air pollution, curative workshops Inc., ethics and deportment, legislation, milk, tuberculosis, and water pollution. An executive committee carries on the routine business and organization work. Other special committees are appointed for special work as needed. The scientific program has always been stressed, from the beginning of the Association to the present time, and probably accounts for the regularly large attendance.

A little before the beginning of this century a new feature was added that might be considered by this body. Committees were appointed and assigned months to report the year's progress in such subjects as anatomy, histology, pathology, and bacteriology—Doctors Chapin and Swarts were on that committee. Other subjects were physiology, chemistry, surgery, diseases of children, *Materia Medica*, and therapeutics, hygiene, obstetrics, and gynecology. Surely that was an ambitious program and designed to elevate the standard of medical education and quality of medical service in a vigorous manner.

It was early 1887 that Dr. Gadding reported an interesting history and autopsy report of one of his patients. After a slight muscular strain she was seized with a severe epigastric pain radiating to the arms, particularly the elbows and finger tips. Within a short time she died. Post-mortem examination revealed a ruptured left ventricle and two ulcers of the aorta, between which the lining membrane had separated. It is too bad that we do not have his actual words instead of a resume by the secretary, for this case antedates Dr. James Herrick's famous paper by twenty-five years.

Without attempting to estimate the value of our recent activities, that would be most presumptuous, the Providence Medical Association seems to be carrying on, about as the Founders hoped and planned. Interest in the programs is evident by the attendance, which appears to be fully as large as those of similar societies in comparable communities. Improvement in medical education and sci-

ence seems to have been one of the Association's major purposes.

Public welfare and service is the other major objective. In recent months this body aroused the public to the effect of air and water pollution. It is interesting to note the public's quick response and their cooperation with the formation of committees to work for enactment of legislation to control such pollution. Other committees, such as the one on Sanitation in Eating Establishments, have rendered a great service to a most grateful public and the response has been stimulating.

We have taken an active interest in economic questions, so far as they concern the patients' ability to secure medical attention. Like the first meetings of this organization and nearly all other similar groups of the time, we have been engaged in minimum fee schedules for the low-income group and are even now about to launch an insurance plan for their protection. Without doubt this plan will be extended in the near future. Cash Sickness Benefits and the Workman's Compensation Act have both received a good deal of attention and study from us.

One wonders what subjects will occupy this Association in 2048. It would be impossible to predict. May we humbly hope and strive to make our efforts sufficiently valuable to excite their admiration as have the Founders of the Providence Medical Association won our admiration.

And now, if these records still exist one hundred years from now, let us extend to the readers of them our sincerest good wishes for their success.

WILMS TUMOR

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greater the possibility of metastasis. Our own experience in dealing with Wilms tumor has led us to resort to immediate nephrectomy when confronted with relatively small and medium-sized tumors and employ preoperative irradiation with large tumors when technical difficulties in their removal outweigh the possibility of metastasis during the intervening period of a few weeks.

The advantage of transperitoneal approach when operating for Wilms tumor lies in the fact that the renal pedicle can be ligated first, before attempting to mobilize the tumor mass and thus avoid escape of tumor cells into the blood stream. Aside from this consideration, transperitoneal route is preferable when dealing with large tumors difficult to be removed through an extraperitoneal lumbar incision.

Drainage through a stab wound in the flank was not done, contrary to the practice of many urologists. As stated above, both of these cases healed per primum. If one is careful to obtain complete hemostasis, I believe drains will not be necessary.

Summary: Two cases of Wilms tumor in the same family are reported. Both of these children were male. In one case the right kidney and in the other the left kidney were involved. Both ended fatally. The familial tendency and mode of therapy discussed.

I wish to thank Drs. Earl F. Kelly and Thomas P. Sheridan and other members of the pediatric service for their wholehearted cooperation in the management of these two cases.

PNEUMOCOCCIC LOBAR PNEUMONIA

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monia by two to three days, in addition to markedly reducing the mortality.

4. Sulfonamides are as effective as penicillin in reducing the length of the natural history of the disease, but cause some complications. Treatment of pneumococcic Lobar Pneumonia with daily penicillin dosages in excess of 300,000 units appears to be the ideal treatment in that the duration of the disease is shortest and complications of the disease and treatment are minimal.

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THE PMA CENTENARY

One hundred years is a dignified age, even in Providence. The Providence Medical Association, which celebrates its centenary this week, was founded during the Mexican War when our city had about 40,000 inhabitants and hospital facilities consisted of Butler Hospital, Dexter Asylum and a pest house for cholera and smallpox, which were serious problems in those days.

Mutual support in economic matters was a strong factor in bringing these physicians together, but the records show that, having once become properly organized, they devoted their meetings to the art of medicine and to its science as it slowly developed.

The small size and compactness of Rhode Island had rather naturally resulted in the formation of the state society first. As population concentrated, however, the local physicians found it convenient to work together without the difficulty of association with their outside friends, kept away by awkward traveling conditions.

Hence the Providence Medical Association grew larger than the Rhode Island Medical Society, for many physicians saw no need of joining both. Although this has been changed now and the state society is larger and dominant, the volume of scientific and educational work remains greater in the association's eight meetings yearly.

Some of the former members' names are still

familiar despite the lapse of time. At the beginning was Usher Parsons, surgeon to Perry at the Battle of Lake Erie and brother-in-law of Oliver Wendell Holmes. Most famous was Charles V. Chapin, who revolutionized public health work and conceived the Providence City Hospital. His ideas about the care of infectious diseases, executed by Dennett L. Richardson, brought visitors there from all parts of the world.

The standards of the association are still high. Many of the younger and middle-aged men are doing the finest of work. So are those with a few more years to their credit. Dr. Halsey De Wolf performed an arduous duty with great judgment when he took charge of the procurement and assignment for doctors in the recent war. Dr. Frank T. Fulton has been one of the leaders in the development of cardiac studies for a good part of this century.

A week of displays and publicity featuring the history of this revered institution will be climaxed on Jan. 31 by an historical address at the Medical Library in the afternoon and a dinner with appropriate exercises in the evening.

May the second hundred years of the Providence Medical Association be as successful as its first.

Reprinted from THE

PROVIDENCE JOURNAL—January 26, 1948

QUANTITY VERSUS QUALITY*

Recently the editor spoke to one of the most scientific members of our local profession and remarked that we liked to produce, ourselves, the matter that filled our columns. We preferred not to copy but we nevertheless expressed such appreciation of a recent editorial in the *New England Journal of Medicine* that we thought of reprinting it. Our friend replied "I think it ought to be reprinted once a week".

There has been a lot of spacious talk regarding the extension of medical care. Statistics are quoted to show the crying injustice of having many counties in the United States without a hospital. Bristol County, Rhode Island, is one of them. Yet its residents can reach the hospitals of Providence easier than some of the residents of Providence County. Much is said of the dearth of general practitioners. Yet it would be futile to increase the number of poorly trained ones. See paragraph four in the following editorial. It is refreshing to read this discussion of *Quantity versus Quality* from the *New England Journal of Medicine*, October 16, 1947.

—THE EDITOR

Much of the thought concerning the distribution of medical care is based on the assumption that there is a store of unused potential medical care that should be properly distributed. We have sowed, harvested and gleaned our learning over the years. Now we are garnering it; let us open up the bins and release it to a long-starved public!

This idea suffers on closer inspection. Medical care consists of knowledge, applied by men to patients. This knowledge is the working capital of medicine, built up through centuries of experience and decades of research. We often proudly refer to modern medical knowledge as of "huge extent" or "staggering proportions," and relative to the accumulated facts of a century ago, this is true. Yet in any given area, knowledge is not so massive that it cannot be encompassed by the human intellect. Knowledge simplifies as it progresses, and multiple ill understood theories are swept away by the strong currents of new basic facts. Each significant advance in medicine renders obsolete a multitude of former writings or practices. There is nothing overpowering in the amount of our present knowledge, but the application of this knowledge to sick human beings is a complex and difficult affair that requires the use of the second medical resource, men. Without men who can apply it properly, medical knowledge is sterile. Unfortunately, an M.D. degree confers neither wisdom nor honesty on the recipient; wisdom in its broader sense includes not only factual knowl-

edge but also the ability to apply knowledge with judgment and mercy. Honesty is the *sine qua non* of medicine, without which medical practice degenerates into the collection of the fee without the contribution of commensurate benefit.

The question at hand is, Do we have any reservoir of men to apply our knowledge, any reservoir that is not drained, any potential that is not kinetic? Do we have any group of competent men whose present time-budget is ready for the expanded services of a legislative medical plan? A moment's consideration will reveal that we do not have such an unexpended surplus; indeed, we are operating with a deficit.

For all their effectiveness, modern medical techniques are dangerous and medical knowledge is of little avail unless applied by men of wisdom and integrity. Modern tools enforce on us the necessity of becoming better craftsmen. When medical care was simple and ineffective it was also harmless, and the fine exercise of judgment required of the present-day physician, working with his sharp and penetrating weapons, was less frequently required. Yet the raw material from which physicians are fashioned has not changed since the day of Currier and Ives.

Recognition of the fact that the American medical profession is not perfect constitutes an unpopular viewpoint in this day of propaganda and institutional advertising; even the pharmaceutical industry seems to be in league to inflate our ego and whitewash our shortcomings. The precient, sentient and omniscient doctor-scientist of the motion pictures and advertisements has become a fixture in the public mind and therefore in ours. Unfortunately, however, the profession does leave much to be desired; this is no disgrace, for any group of 160,000 men is too large to be called "select." The members of the medical profession possess all the virtues and all the faults of any large cross section of population. In addition to the wise and honest doctor-scientists, we have our full share of loud-mouthed snap diagnosticians; and researchers who are long on theory but short on judgment are as numerous as surgeons whose concern for the patient fades if convalescence is stormy.

These facts and this deficit of quality are disturbing only if we set out to distribute our allegedly undistributed medical care by legislative extension of medical services. In creating a broad national medical-care plan it should be recalled that the harm done by poorly qualified men becomes multiplied as the square of the number of patients they treat. There are all too few physicians who exemplify the best in the profession, and they are already overburdened.

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GUEST EDITORIAL

AN EXCURSION AMONG THE EPONYMS

"But these are deeds that should not pass away, and names that must not wither."

Byron, quoted by Jessie Dobson.

In the past, and that not so far distant, we have enjoyed the scholarly yet picturesque talks of Dr. George Blumer of Yale. Dr. Blumer is now retired and is enjoying in California what he would probably call, were the expressions not so trite, his dolce far niente or his otium cum dignitate.

But it is not in Dr. Blumer's nature to do nothing, and he has recently written some delightful editorials for the Connecticut Medical Journal. Dr. Elihu Wing is a friend of long standing of Dr. Blumer, and it is thanks to that that we are privileged to print the following editorial by Dr. Blumer.

—THE EDITOR

ALMOST fifty years ago, "in my salad days when I was green in judgment", I wrote an editorial entitled "The Use of Proper Names in Medicine".* In it I decried the habit of labelling new diseases and new symptoms with the names of their discoverers, mainly on the ground that "the unfortunate medical student, who is already overburdened with work, is compelled to memorize a series of names, some of which are doubtless those of eminent men, but others those of individuals whose only claim to posterity is their association with some minor symptom or ailment." It is possible that this attitude was at least partly due to the fact that I was then only a decade from my early student days and had not entirely sloughed off the memory of the then prevailing lecture system with its hours of note-taking on hard benches. But, be that as it may, I no longer look on Eponyms with a jaundiced eye and, agreeing with Emerson's dictum that "a foolish consistency is the hobgoblin of little minds," I have changed my views regarding them.

The custom of associating the names of discoverers with the observation and description of new phenomena and new objects permeates all the Sciences and is by no means confined to Medicine. As I look out of the window I see a bougainvillea, and the names of Wistar, Forsyth, and even popular heroes like Fremont, are associated with well-known plants. As Jessie Dobson says in her book, *Anatomical Eponyms*, "botanical nomenclature serves as a directory of the great pioneers in the

* Albany Medical Annals 1899, 20, 613.

study of that subject." The zoologists, the physicists, the chemists, the geologists, and in Medicine the bacteriologists, the pathologists, the physiologists, the chemists and the clinicians all use personal names at times. Even our newspapers are invaded by such terms as Kilowatt, degaussing, and many other eponymic words, not to mention every day adjectives such as herculean, rabelaisian, venereal.

Theoretically, at least, a medical term should be descriptive, and in the case of a disease, should give clues as to the etiology and pathology of the condition. The fact that the names of some diseases meet these requirements and that others entirely fail to do so is evidence of the lack of a generally accepted plan governing nomenclature. The anatomists with their B.N.A. have tried to tackle the problem scientifically with the result that they have demonstrated pretty conclusively that a given group of men in any science would almost surely fail to reach a unanimous agreement to eliminate eponyms. There was a period in the Eighteenth Century when the French botanist and physician De Sauvages tried to introduce a sort of Linnean classification of diseases on which the English clinician John Mason Good tried to improve. The result was an appalling and cumbersome mess of verbiage which was never widely adopted and soon sank into innocuous desuetude. In clinical medicine new diseases arise from time to time or opinions regarding old maladies have to be revised in the light of new discoveries. It is only occasionally that all the facts as to the etiology and pathology of a disease are known when it is first described, indeed there are even now old diseases, some of which have been known and recognized clinically for generations, whose etiology is still a mystery; one need only instance one of the commonest of all affections, arteriosclerosis, as an example.

In addition to burdening the memory of the physician and the medical student the use of eponymic names for diseases or syndromes has other disadvantages. Very often the individual who first described the disease does not get the credit, though since the publication of the Index-Catalogue of the Surgeon General's library, the Index Medicus, and the Quarterly Cumulative Index this

is less likely to happen than in former days when an interminable search through available literature was necessary to try and ferret out the question of priority. Combe gave a pretty good account of pernicious anemia years before Addison did; Vieussens described Corrigan's pulse before Corrigan was born, and many other similar incidents could be cited. The question that such occurrences always raises is this: who should get the credit the man who originally describes a disease, perhaps reporting a single case only, or the man who really "puts it on the map", usually by studying and analyzing a series of cases and presenting a detailed and systematic picture? Then, too, several men may discover the same disease independently, so, for example, the names of Graves, an Irishman, Parry, an Englishman, and Basedow, a German, are all attached to Exophthalmic Goiter, and Polycythemia Vera is often named the Osler-Vaquez disease. The fact that the name of a disease may give no clue to its nature is a valid criticism of the use of eponyms, but one on which too much stress should not be laid. Many eponymic diseases also have scientific names and, as a matter of fact, if their nature is obscure, they may have many such. One has only to read the history of Hodgkin's disease with its multiplicity of synonyms to realize this. Furthermore it does not take students or practitioners long, if they are really interested, to learn the various names of eponymic diseases and to associate them with the etiology, the pathology and the clinical picture.

What are the advantages of an eponymic nomenclature? Brevity is sometimes one of them. It is easier to say Bamberger-Marie's disease than hypertrophic pulmonary osteo-arthritis. Another advantage is that, for the most part, it gives credit where credit is due and, most important of all, it encourages the study of medical history, which, like other history, is mostly biography. It was always dangerous for a house officer or student of William Osler to use an eponym. He would almost certainly be asked who the man was whose name he had used, and if he didn't know he would be told to look it up and report to the group at a later date. William Allen Pusey, the well-known dermatologist, once wrote an article entitled "The Importance of Being Historically-minded", and there is no question that knowledge of the past is essential to the formation of a well-balanced judgment of the present. Studying history through biography is one of the most attractive ways of acquiring knowledge of the past, and this aspect of the eponymic diseases outweighs, I think, all the objections to this type of nomenclature.

QUANTITY VS. QUALITY

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How can this deficit be met? Is there any way of multiplying the good medical care dispensed by one person? In a limited sense, yes. One occasionally encounters that happy circumstance in which an older man surrounds himself with a group of devoted and effective residents or associates in a hospital or clinic and thus extends his reactive interface with the public. But this is a rare phenomenon. More frequently the able, older man becomes increasingly absorbed in administrative or other noneffective duties that enhance his national reputation but limit rather than extend his contact with the public. This type of work should be delegated to personnel trained for that purpose, not to the best clinicians and investigators.

Is there any way of increasing the total number of effectives? Better recruiting should be the answer. The admission committees of medical schools must raise their standards by every honest means. The interest and enthusiasm of the most capable undergraduates in the colleges must be aroused. The breed must be improved, even if it requires artificial insemination!

Until we have succeeded, let us not try to dispense to the public more medical care than we possess. We must meet our present deficit of quality before incurring any more obligations for quantity. One may raise the objection that the public will not wait — that labor unions or insurance groups will insist on the extension of medical care. Let them light the fire; they will be badly burned and learn their lesson. Some well intentioned and well financed group will establish a medical-care plan and, by chance or ignorance, will place it under the direction of poorly qualified physicians. The patients will be cared for by men with "pet theories," which were formerly inflicted on relatively small groups of private patients, or by surgeons long on speed and short on incisions. But these patients will not drift off into the happy limbo of another man's practice. They have made their prepayments over the years and they will return for amends; the bad news will gather like flies around offal on a hot summer day. The backers of this scheme will come to realize that, although their expenses have been met, they are operating under a deficit — a type of deficit peculiar to medical undertakings.

The definition and control of competence is the central problem of medicine today. It seems wiser to move toward the solution of this problem than to multiply the total number of doctor-patient contacts by legislation.

*Reprinted from *The New England Journal of Medicine*, October 16, 1947.

GROUP MEDICAL PRACTICE*

FREDERICK T. HILL, M.D.

The Author. *Frederick T. Hill, M.D., of Waterville, Maine. Director, Thayer Hospital, Waterville; Trustee, Colby College.*

GROUP PRACTICE may be defined as the pooling of professional and material resources with the objective of more efficient medical service, economically advantageous both to patient and physician. It should represent the practice of diagnostic, therapeutic and preventive medicine by an integrated group of physicians, including general practitioners and qualified specialists in as many different fields as possible.

The greatest criticism of American Medicine, and about the only one freely admitted by everyone, is that the prevailing system for distributing medical care is decidedly inefficient. There is no doubt that this phase of medicine has not kept pace with its technological advances, so that the best service is not always available to those needing it. The main problem of medical care today is that of distribution.

The realization of this has influenced the consideration and development of group practice as one means of providing better distribution. Experience has shown that a rather high percentage of cases require the attention of specialists in various fields, if the best of medical care is to be provided. This can be met most effectively in most cases by group practice, where by centralization of resources specialist skill can be effectively utilized and compensated for. It has been estimated that group practice can increase the efficiency of delivering medical service by 50%.

Unfortunately too much emphasis has been placed upon the economic phase, rather than upon the more important objectives of better medical service. And, unfortunately, too many groups have been formed, or entered into, with the main idea of financial gain, or at least making money with less effort.

While there are, of course, definite economic advantages through the pooling of material resources, the greatest reason for group practice is in the improved quality of medical service that is

made possible through the facilitating of consultations and of group study. The greatest value would seem to be in the increased emphasis upon cooperative professional effort, with better diagnoses and less delay in effecting proper treatment. How often do we see a patient with some obscure condition making the rounds of physicians until finally a diagnosis of carcinoma is made by the specialist in some particular field? Group study at the onset might have indicated the diagnosis and allowed for effective treatment before the condition became too advanced.

The real argument for group practice should be that by pooling professional resources better and more scientific medical care is made available for more people.

Group practice means something more than several physicians with adjoining offices, sharing in certain items of overhead and exchanging consultations among themselves. It means actively and conscientiously using their combined professional skills, and mutually accepting the responsibility for the care of the patient.

In general there are three types of Group Practice prevalent in this Country. The best and most efficient type is that with University or teaching hospital affiliation. While the degree of affiliation may vary, there is an inevitable tendency to maintain high standards and they are the least affected with the taint of commercialism.

Another type, usually designated as a Clinic, may be quite independent of academic affiliation, or this may develop later as a result of successful operation along scientific lines so as to make its resources appealing to a medical school or teaching hospital. Most of these are either privately owned or may be in the nature of a partnership or a corporation with the physicians as share holders.

A third and more recent type is that organized around some sort of pre-payment plan, on insurance principles. In some cases this type of group may base its activities in some hospital; in others, it may use independent hospitals.

Good Medicine, whether individual or group, should aim to provide the best possible diagnostic and curative service at a cost consistent with the patient's financial status. Illness should not entail economic catastrophe. Loss of earning power

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* Presented at the Third New England Institute for Hospital Administrators, at Providence, June 26, 1947.



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GROUP MEDICAL PRACTICE

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alone is enough of a burden to bear. Hospital insurance should be easily available to all employed persons through the Blue Cross or similar plans, and the hospitalization of the indigent properly should be met from general tax sources. The development of prepayment medical care insurance should lessen the burden of professional fees; but, whether or not, if Medicine is to retain its Time-hallowed reputation as the most humane of professions, it must not carry a price-tag. Fees, in all cases, should always be consistent with the patient's means.

Group practice has been criticized as being too elaborate for the ordinary type of illness, as tending to create cliques, as limiting the choice of consultants and of sometime providing substandard service from unqualified self-labelled specialists. The validity of these criticisms depends, to a great extent, upon the type of group and the individuals composing it. Like the hospital, any group will be only as good, or as competent, as its physicians. Any such plan undertaken primarily for commercial reasons, either to increase the physicians' income or even to reduce expenses, would hardly merit approval. Similarly any plan which limited the choice of consultants, or tended towards cliques based upon mutual self-interest could only meet with disapproval. The welfare of the patient always must be our first consideration.

For years the larger teaching hospitals have embodied the principles of group practice in the care of their service cases. Perhaps the outstanding feature in our changing professional relations in hospitals has been the gradual, often unconscious, extension of these principles to all patients. It has been the logical thing to pool professional resources in the hospital. This implies group study of cases whenever indicated, the liberal use of consultations and transfers to other services, or physicians, if the patient would benefit thereby.

Because of this tradition it is easy to understand why the type of Group Practice, affiliated with University or teaching hospital, usually has the highest standards, the most scientific methods and the least taint of commercialism.

If there be merit in this idea of group practice, if it will at least help solve the problem of more efficient distribution of medical care, could it not be applied in varying degree, at least, to the average community hospital? The voluntary hospital would not consider the privately, or corporation owned type but an adaptation of the first type, that with academic or teaching hospital affiliation would seem possible and desirable.

The principle that the hospital should assume the responsibility for the safety and the medical care

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of its patients, both service and private, is now rather generally recognized. The private patient is no longer to be considered the personal medical property of his physician. Rather he is the hospital's patient, under the care of the physician; but with the hospital through its staff, responsible for diagnosis and treatment. The consensus of medical minds of the staff should be available to determine whether or not proper treatment is being carried out. This may indicate the need of consultations, of additional diagnostic procedures, or a complete change of therapy, or even of physicians. At first hand this may seem revolutionary to some but if the patient is to be assured of the best care and the hospital is to live up to its responsibilities, this must be accepted.

And this, of course, is group practice in the hospital. And it's not new, or revolutionary. It's simply the adaptation to all patients in all hospitals of the accepted principles of what we have termed the teaching hospital, which has produced the best type of Medicine the World has ever seen.

In this connection I dislike the designation "teaching hospital". All hospitals, regardless of size or location, should be teaching hospitals. I say "should be" advisedly for I realize that many hospitals fail in this respect today. But each hospital should strive to develop the "teaching idea" in its daily routine. In no other profession is a program of Continuation Education so necessary as in medicine. So often the recovery, the health or even the life of the patient depends upon the skill and knowledge of the physician. And medical science is not static. What better place to carry on a program of Continuation Education than the hospital, every day and every week? Any good hospital will have teaching material if only it is made use of. This should include private as well as service cases. Often they provide the best material, that needed for teaching purposes. Patients, as well as physicians, benefit from case study. Self-education, after all, is the most valuable form of education. To neglect this, substituting an occasional short course in some teaching center, is both lazy and wasteful. It is time we were weaned from an exclusive regime of spoon-feeding. The weekly staff meeting, if properly planned and conducted, is one of the best forms of education. It can and should make all hospitals teaching hospitals. Hospitals will vary in size and in scope but all should strive for the same high ideals and have the same standards of service.

With this idea of group or cooperative practice it is easy to arrange for attendance at National and Sectional Scientific meetings, so necessary to enable men to keep abreast of medical progress. By dividing the assignments the staff may be represented at all the important meetings and the

continued on page 118

In behalf of the medical profession

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Write Parke, Davis & Company, Detroit 32, Michigan.

Some things you should know about the common cold

No. 209 in a series of messages from Parke, Davis & Co.
on the importance of prompt and proper medical care.



MOST PEOPLE in the United States and Canada have two or more colds a year, each lasting about two weeks and causing a considerable amount of stuffy discomfort.

The danger of the common cold lies mainly in the other infections that may follow after it. For a cold lessens your resistance, and is likely to pave the way for other, more serious, respiratory ailments.

Sinusitis, ear infections, bronchitis, and the various forms of pneumonia are frequently ushered in by a cold. Pneumonia, particularly, is likely to attack a person who is overtired, or run-down because of a severe cold.

True, many of these respiratory diseases are not as dangerous as they used to be. (Modern infection-fighting drugs—such as penicillin and the sulpha drugs—offer highly effective treatment for many cases.)

But, of course, it is always better to *prevent* a serious illness whenever possible.

If you have a cold, it's just good sense to stay away

from people, to avoid spreading the infection; and to get plenty of rest—in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness.

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever.

SEE YOUR DOCTOR. Never try the foolhardy experiment of dosing yourself. Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

Let your doctor diagnose your ailments. Let him decide what treatment is best for your particular case. Then follow his instructions to the letter. His advice is the only advice you should take on any question that concerns your health.

Makers of medicines prescribed by physicians
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proceedings reported back, while at the same time the patients are adequately covered.

In our own hospital we have gradually developed a system of cooperative effort in the care of the patient, which, while not strictly group practice, has resulted in such a pooling of professional resources. This has promoted better standards of medical service, provided better care of the patient and increased the scientific attitude of the staff. And the physicians like it and find it worthwhile.

This idea of cooperative practice works so well both for the patient and the physician, and is so logical and so productive of improved service, that it is bound to grow. There is great satisfaction for any physician in doing better, more efficient, more scientific work, such as is made possible by this pooling of minds and skills. It is one of the best means of attracting the desirable type of physician to the hospital. And those who will not subscribe to cooperation are not especially desirable and had best be eliminated. They will be far happier in other surroundings and the hospital will be better off without them.

Group or cooperative practice in the hospital is not difficult of application provided there be at least a semblance of departmentalization and a limiting of professional privileges according to the qualifications and competence of the staff physicians. Patients can be routed to the proper service and often to the best qualified man, or suggestions made for his coming into the case. Consultations can be encouraged and insisted upon, with a small ceiling fee for patients able to pay and freely given for those in poorer circumstances. Staff or departmental consultations on all serious or problem cases make for group practice. And this seems to work quite as well in the out-patient as with the house cases.

A logical step would seem to be the greater development of group facilities for diagnosis prior to hospital admission, and the utilization of these facilities for the treatment of ambulatory patients, not requiring hospitalization. If developed under the aegis of the hospital, this should be free of any taint of commercialism. There are sound professional and economic arguments for such a plan, such as readily available consultations, specialists services, X-ray and laboratory facilities and the saving of the physicians time, a large portion of which is spent daily in the hospital.

I am not particularly concerned with just how this is done, provided the main objective of better diagnoses be achieved. Local conditions must be

the determining factors, and cooperation, congeniality and mutual respect are essential. The full-time salary plan has certain advantages and also is open to certain criticisms. Many physicians are, by nature, rugged individualists and object to anything smacking of regimentation. And this plan calls for expert administration to succeed. In some circumstances the use of group offices in the hospital on a rental basis, with the unit system of fees for cases seen by the group, might be desirable. The fee should be based upon; first, the value of the service to the patient, considering his financial status, and second, the relative value of the services of the several physicians concerned. This type might be more adaptable to a group which was to include a number of older, well-established physicians. And as patients could come first to the physician of their choice, the personal relationship would be preserved. It is just a more efficient method of getting consultations, eliminating the psychological and economic barriers that often prevail.

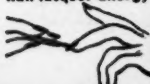
The scope of such a group will, of course, vary according to the size of the staff and the various specialties represented. The small community hospital staff may consist entirely of general practitioners, with perhaps one man doing part-time X-ray work. Despite these limitations such a group could practice more efficient medicine than by working individually. Consultants from larger centers could be utilized when necessary. And as the need developed it would not be so difficult to attract specialists in different fields.

At the same time it is not necessary, and indeed may not be desirable, to include the entire staff membership in such a plan. There may be physicians serving the hospital most satisfactorily who might not be especially useful for the purpose of the group, or who would not care to become affiliated with it. A good working unit, including as many specialists as is possible, should be the objective, and members should be selected for their particular ability. With larger staffs the senior men ordinarily would be the natural selections, with the younger men serving in junior capacities. Services might be rotated, just as in the hospital. But these are details to be solved on the local level.

The main thing is to provide better professional service, both in the hospital and for the ambulatory patient, to substitute cooperation for competition, and to do this without imposing undue financial burden on the patient. And, above all, to accomplish this by a method devoid of political or bureaucratic control. It would seem a natural and logical development for the voluntary hospital.

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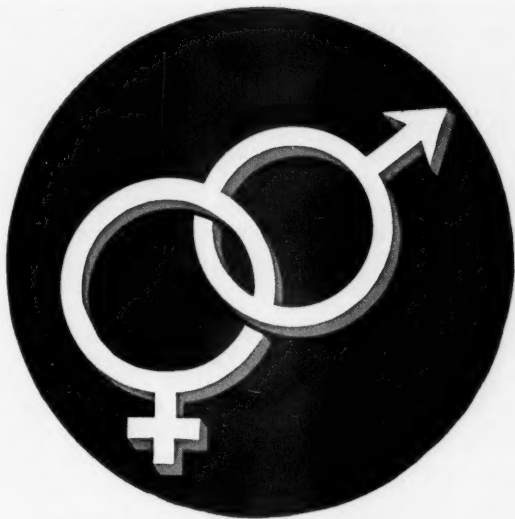
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1. Gusberg, S. B., Am. J. Obst. & Gyn. 50:502, 1945

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HOUSE OF DELEGATES of the RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on January 21, 1948

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the medical library on Wednesday, January 21, 1948. The meeting was called to order by President Arthur H. Ruggles at 8:40 p.m.

The following delegates were in attendance:

Rocco Abbate, M.D.
Charles J. Ashworth, M.D.
Philip Batchelder, M.D.
J. Murray Beardsley, M.D.
B. Earl Clarke, M.D.
Frank B. Cutts, M.D.
Morgan Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
David Freedman, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Earl J. Mara, M.D.
Edward A. McLaughlin, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
Arthur H. Ruggles, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.
Frederick A. Webster, M.D.

Also in attendance were Dr. Stanley Sprague, Chairman of the Committee on Industrial Health, Dr. Clifton B. Leech, Chairman of the Providence Medical Association Advisory Committee to the Community Workshops, Inc., and Mr. John E. Farrell.

The secretary presented a brief report, a copy of which had previously been mailed to each member of the House. This report required no action by the House.

Industrial Health Report:

Dr. Stanley Sprague, chairman of the Committee on Industrial Health, reported as follows:

"At the November 24, 1947, meeting of the House of Delegates two recommendations were made after the report of the committee on Industrial Health relative to changes in the Workmen's Compensation Program had been adopted.

"These recommendations, referred to the Committee on Industrial Health were:

- 1) That in regard to the signs relative to the free choice of physician under the Workmen's Compensation Program larger type be used, and every effort be made by the Workmen's Compensation Agency to guarantee that the notice is posted prominently where it can be read by workers.
- 2) That the panel of physicians proposed should be available to private physicians who want their opinion substantiated that the patient can return to work.

"In relation to the first recommendation the members of the committee feel that this is outside their province in the first place, but that they do recommend that all copies of Workmen's Compensation Laws required to be posted in various factories, etc., not only be checked as to the fact of their posting but also be in larger type so that they may be more readily seen and read by workmen who are injured.

"Secondly, that if a medical advisory board is established by the Workmen's Compensation Commission, that this advisory board be available to individual physicians treating compensation cases to assist them in determining the ability of workers to return to their work. (It is often felt by the individual physician that his patient is ready but this patient cannot be persuaded to return and insists on further treatment. It is at this point that the committee feels that the physician should have power to request the review by this medical advisory board.)

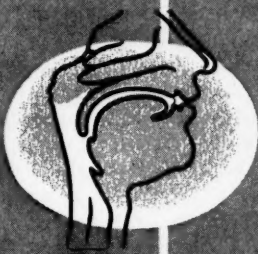
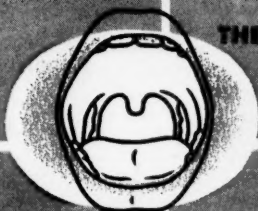
"The committee, therefore, recommends that if the House adopts these suggestions the action of the House be transmitted to the State Workmen's Compensation Law Commission."

After brief discussion of the report of the committee it was moved that it be the expressed opinion of the House of Delegates that such industrial plants in Rhode Island as have a list of physicians on call in case of accidents occurring during working hours shall prominently display such list with a heading at the top stating clearly that the injured worker has free choice of physician at all times,

continued on page 122

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HOUSE OF DELEGATES MEETING

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and stating further that if the injured worker does not have a physician of his own choice, then the employer may call one of the physicians on the stated list.

The motion was seconded and adopted.

Communication from the Providence Medical Association:

A communication directed to the Executive Committee of the Providence Medical Association by the Association's Advisory Committee to the Community Workshops, Inc., was considered by the House of Delegates. This communication was referred to the House by the Association's Executive Committee because the matter involved an action taken by the House of Delegates at its meeting in November, 1947.

Dr. Clifton B. Leech, chairman of the Association's Advisory Committee to the Community Workshops, Inc., discussed the problem as presented in the communication. He stated his committee took exception to recommendation 5 in the report of the Industrial Health Committee as adopted by the House in November, which pertained to the use of the state curative center by private physicians, and he stated the committee expressed the hope that the House would withdraw its approval of that portion of the recommendation.

The matter was discussed at length by several members of the House, after which it was moved that the House of Delegates, having received and discussed at length the communication from the Providence Medical Association's Advisory Committee to the Community Workshops, Inc., place it on file.

The motion was seconded and passed.

Committee on Health Insurance:

Dr. Rocco Abbate, chairman of the Committee on Health Insurance, presented a brief summary of the present status of the surgical insurance program, citing that the policies of five major insurance companies have been approved and those of two other companies had been received that day for viewing by the committee. He also reported that a conference had been held with the Blue Cross and that organization had been urged to explore every possibility whereby it might participate and then present its proposal for participation to the committee.

He also reported that 550 Fellows of the Society had signed as participating physicians, and in addition, the staff of the Truesdale Hospital in Fall River had voted to endorse the program and participate in it.

He reported further that three local insurance authorities had been invited to serve as insurance consultants to the committee.

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For the committee Dr. Abbate requested a decision from the House of Delegates relative to the publication of the list of participating physicians.

DISCUSSION . . .

There was brief discussion of the report and of the distinction between a participating and a non-participating physician. At the conclusion of the discussion it was moved that the House of Delegates authorize the Committee on Health Insurance to release to the insurance companies participating in the program, and to the press, if necessary, a list of the participating physicians for the surgical insurance plan. The motion was seconded and passed.

Scientific Work and Annual Meeting:

Dr. Arthur H. Ruggles, chairman of the Committee on Scientific Work and Annual Meeting, reported briefly on the plans for the mid-winter meeting of the Society to be held on Monday, February 2. He also reported that the program for the annual meeting in May was almost complete.

Committee on Medical Examiners:

Dr. B. Earl Clarke presented the report of the joint committee of the Rhode Island Medical Society and the Rhode Island Bar Association relative to the existing laws concerning medical examiners in Rhode Island. Copies of the report were submitted to the members of the House of Delegates and a copy is appended to and made a part of the official minutes of this meeting.

Dr. Clarke moved that the House of Delegates approve the report and submit it to Governor John O. Pastore. The motion was seconded.

Dr. Rocco Abbate questioned the recommendations of the report as not stipulating the duties of the medical examiners. He also criticized the proposal for a central office, citing that such an arrangement would require that all bodies be brought to Providence for autopsies.

Dr. Clarke stated that the reason the committee did not recommend that the medical examiners have final say on performing their own autopsies was because the medical examiners did not wish to assume that responsibility but expressed a preference that it be left to the attorney general's office.

Regarding the central office and post mortem laboratory located in Providence, he stated that in the opinion of the committee a post mortem could be done better in the examiner's own headquarters with the aid of his assistant and facilities there. He also stated that it would be less expensive to transport the body than to take a team of men about the state to conduct the examination.

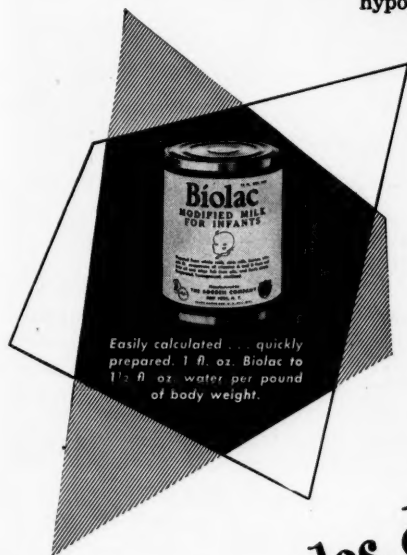
Dr. Ashworth queried as to what were the reactions of the medical examiners relative to the

continued on page 124

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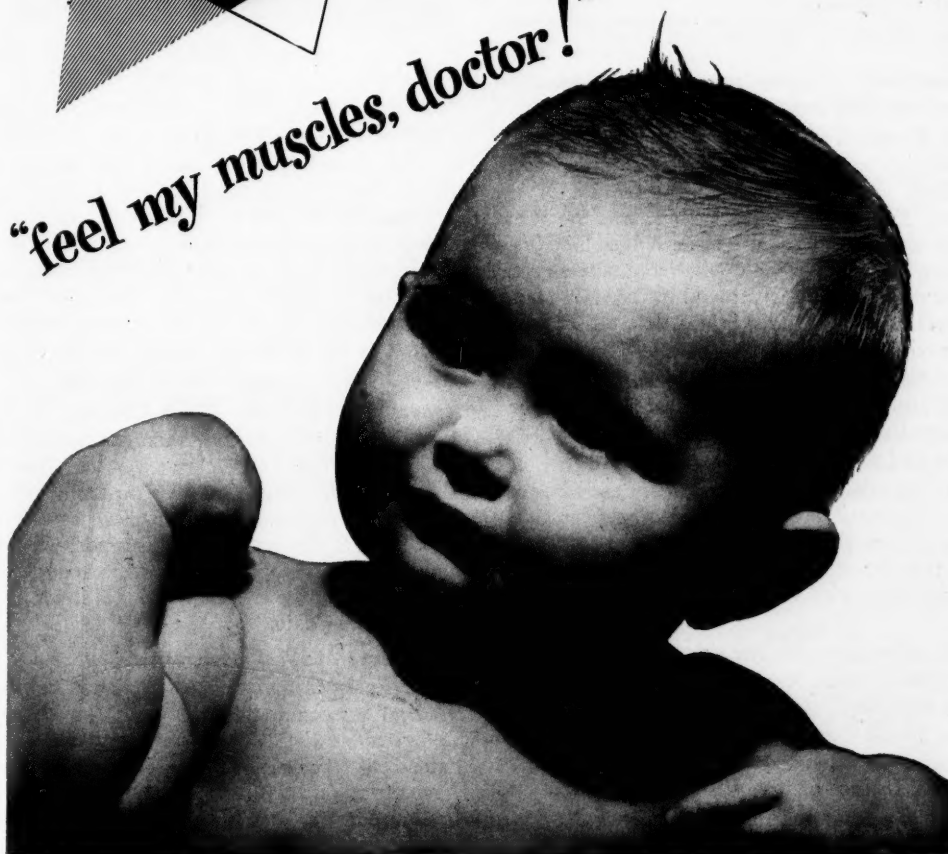


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HOUSE OF DELEGATES MEETING

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problems. Dr. Clarke stated that there was no unanimity of opinion. Some favored a change; others didn't.

Dr. Ruggles called for a decision on the question.

The House of Delegates adopted the motion made by Dr. Clarke to approve the report and submit it to the Governor.

Nominations for Board of Directors of the Blue Cross:

Dr. Ruggles reported the request of the Blue Cross for seven nominees from the Rhode Island Medical Society to serve as members of the board of directors of that organization. He discussed the matter briefly and expressed the opinion that the Society should be actively represented.

There was no discussion, and Dr. Abbate moved that the House renominate as its representatives on the board of directors of the Blue Cross the men who had represented the Society during 1947, as follows: Doctors Samuel Adelson, Philip Batchelder, Edward S. Brackett, William P. Davis, Frank W. Dimmitt, G. Raymond Fox, and Albert H. Jackvony.

The motion was seconded and passed.

Nominations for Committee on Staff Organization of the Veterans Hospital:

Dr. Morgan Cutts, secretary, reported that each hospital except Westerly had submitted three nominees in accordance with the request of the House of Delegates. This request was the result of the action of the House at its November, 1947, meeting to create a state-wide committee representative of the hospitals to aid in the staff organization of the new United States Veterans Hospital in Providence.

Dr. Mara moved that the House ballot on the list of nominees submitted and that the ten highest be named as the committee. The motion was seconded and passed.

The question was raised whether each hospital should be represented or the ten men receiving the most votes. The chair ruled that in accordance with the motion passed the ten men receiving the highest number of votes should form the committee.

The tellers recorded the vote showing one nominee with 17 votes, two with 12 each, four with 10 votes each, and four with 9 votes each.

Dr. Frank Cutts moved that the Committee be expanded to include eleven nominees with the most votes. The motion was seconded and passed.

Dr. Ruggles noted that both he and Dr. David G. Wright of Butler Hospital were included and

RHODE ISLAND MEDICAL JOURNAL

he stated that he felt that hospital should not have two representatives. Therefore, he withdrew his name and requested that the committee of ten be elected.

At this point Dr. Joseph C. O'Connell called attention to the original motion to establish the committee made at the meeting of the House of Delegates in November, 1947, calling for a committee to be representative of all the hospitals in the state. He moved that the House reconsider the action already taken and that it take a new ballot to carry out the intent of the original motion to provide for representation of each hospital.

Dr. O'Connell's motion was seconded and passed.

A new ballot was recorded and the tellers reported the following with the highest votes:

David G. Wright, M.D., Butler Hospital

Edward A. McLaughlin, M.D.,

Charles V. Chapin Hospital

Walter S. Jones, M.D., Lying-In Hospital

Henry J. Hanley, M.D., Memorial Hospital

Herman P. Grossman, M.D., Miriam Hospital

James C. Callahan, M.D., Newport Hospital

Herman A. Lawson, M.D.,

Rhode Island Hospital

Harry Darrah, M.D.,

Roger Williams General Hospital

Fred Burns, M.D., St. Joseph's Hospital

Charles B. Ceppi, M.D., South County Hospital

Alfred E. King, M.D., Woonsocket Hospital

Dr. Russell R. Hunt moved that the Committee on Staff Organization of the United States Veterans Hospital be a committee of twelve consisting of the eleven members nominated by the House of Delegates in the ballot taken, and to include also a member from the Westerly Hospital to be nominated by that hospital and thereby appointed by the President of the Society.

The motion was seconded and passed.

Report of the Delegate to the A M A:

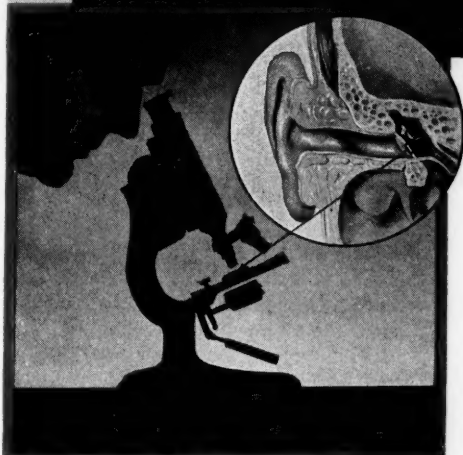
In the absence of Dr. Herman A. Lawson, Delegate to the House of Delegates of the American Medical Association, Dr. Morgan Cutts read his report of the meeting held at Cleveland on January 5 and 6. He stated that this report was a preliminary one and that the complete report would be published in the RHODE ISLAND MEDICAL JOURNAL at a later date.

Providence Medical Association Centennial:

Dr. Earl Mara, Delegate from the Pawtucket Medical Association, moved that the House of Delegates of the Rhode Island Medical Society extend its felicitations to the Providence Medical Association on the occasion of its centennial celebration. The motion was seconded and unanimously carried.

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THE RHODE ISLAND MEDICAL EXAMINER SYSTEM

Report of the Joint Committee of the Rhode Island Medical Society and the Rhode Island Bar Association

DURING the past several years the laws relating to medical examiners have frequently become the subject of discussion and there has been expression at various times that these laws were in need of revision. To study the present laws a committee of the Rhode Island Medical Society was appointed. This committee, in turn, requested the assistance of the Rhode Island Bar Association. The bar association appointed its committee to assist in this study and the joint committee has met several times. During its study the joint committee has investigated the cost of the Rhode Island medical examiner system, and has broken down this data into counties for the past three years; determined the number of autopsies held during the past three years; and correlated the existing statutes of this state relative to medical examiners.

It has conferred with numerous medical examiners of the state and given an opportunity to all medical examiners to express their views in favor or in criticism of the existing situation and to make suggestions for improvement in the law. The committee has also considered and discussed written communications from medical examiners of this state.

The committee has conferred with Dr. William Magill, senior of the medical examiners of this state; with Dr. Alan Moritz of the department of legal medicine of the Harvard Medical School, and with a representative of the attorney general's office of this state.

The Committee has abstracted and discussed the laws relating to medical examiners of the states of Virginia, Maryland, New Jersey, Oklahoma and Massachusetts.

As a result of its study the committee submits the following recommendations. Many details, as for example, the duties of county medical examiners, have not been elaborated — the committee feeling its function to be reviewing the general structure of the law rather than rewriting the statute.

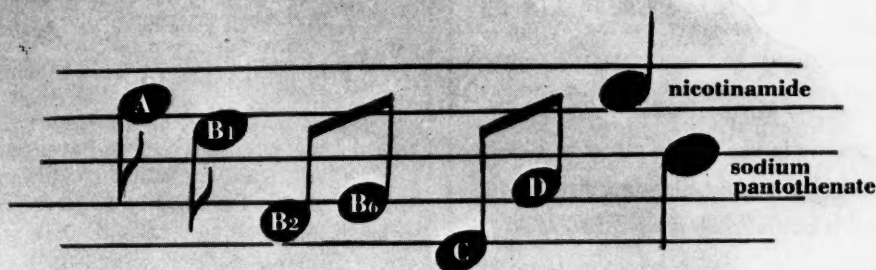
The committee's recommendations are as follows:

1. That there be established the office of chief medical examiner for the state as a full-time position at a salary sufficient to attract a capable person whose duties would include the performing of all autopsies required by law and also acting as state pathologist.

2. That there be an assistant medical examiner appointed by the chief medical examiner to perform the duties of the chief medical examiner in the latter's absence, as for example, during vacation, illness, etc., and that the assistant medical examiner be one of the county medical examiners.
3. That the appointment of the chief medical examiner remain within the department of the attorney general; that he be appointed for a period of six or eight years, subject during his term to removal for cause.
4. That the chief medical examiner, the assistant medical examiner, and the county medical examiners be doctors of medicine, and that the chief be qualified in pathology and have at least one year of medico-legal training.
5. That provision be made for a central office for the chief medical examiner with adequate clerical assistance and a post-mortem laboratory located in the city of Providence.
6. That the chief medical examiner be authorized to call upon and employ, as occasion necessitates, such persons skilled in science or otherwise, as will aid him in the performance of his duties.
7. That there be a reduction in the present number of county medical examiners so as to provide for six county medical examiners for the counties of Providence and Bristol and two for each of the other counties of the state.
8. That county medical examiners be appointed by the chief medical examiner (subject to the approval of the attorney general) and hold office for four years, subject during their terms to removal for cause.
9. That the fees for county medical examiners be revised, so as to provide
 - (a) \$10 for a view.
 - (b) \$25 for assisting at an autopsy.
 - (c) Travel fees as fixed for other state employees.
10. That the chief medical examiner be not entitled to additional compensation for testifying in court, but that county medical examiners be paid for so testifying, the rate of compensation to be determined by the attorney general.

continued on page 128

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RHODE ISLAND MEDICAL JOURNAL

R. I. MEDICAL EXAMINER SYSTEM

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11. That the statute defining the duties of medical examiner be revised along the following lines:

Upon the death of any person from violence, or suddenly when in apparent good health, or when unattended by a physician, or in any suspicious or unnatural manner, or as the result of an abortion or suspected abortion, the county medical examiner shall be notified by the attending physician, law enforcement officer, undertaker or hospital or by any other person having responsibility for burial or cremation.

12. That where a person dies suddenly on a public highway or elsewhere in the public view from apparent natural cause the removal of such body to an appropriate place may be ordered by any superior police officer as well as by others now having such authority.

As stated above the committee has not attempted to rewrite the law in its entirety. It feels that this is indicated only if its recommendations are approved. The committee has therefore confined itself to a broad consideration of the law and methods for its improvement.

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EDWARD A. McLAUGHLIN, M.D.

WILLIAM H. FOLEY, M.D.

HOUSE OF DELEGATES MEETING

concluded from page 124

At the request of the chairman, Dr. Philip Batchelder spoke briefly of the plans of the Association for the observance of its centennial.

The meeting adjourned at 11:20.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

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THE WORKMEN'S COMPENSATION LAW

Report of the Committee on Industrial Health of the Rhode Island Medical Society, adopted by the House of Delegates, November 24, 1947

EARLY in the spring of this year the Committee on Industrial Health held meetings with the Chief of the Division of Workmen's Compensation of the Rhode Island Department of Labor, and with representatives of insurance companies writing the bulk of the liability for industrial concerns subject to the law. In both instances the only complaint voiced was that a few doctors (three or four) were seemingly making excessive charges for diathermy treatments.

The Committee for the Society offered to use whatever power it possesses to discipline any of Rhode Island Medical Society members abusing any privileges granted under the Compensation Act, provided evidence was submitted with which to substantiate the accusation against the individual physician. Neither the Chief of the Workmen's Compensation Division nor the insurance company representatives were willing to present concrete evidence to support their complaint. The Committee called to the attention of the Workmen's Compensation Division that it is within the power of the Labor Department of the State to take action if it finds any charges excessive, and called to the attention of the insurance representatives that the Committee was prepared at any time to assist in advising whether a fee charged for service to a beneficiary of the Workmen's Compensation Act is beyond the prevailing fee charged to the Community.

When legislation in the General Assembly was introduced to provide for the creation of a Workmen's Compensation Law Commission, this Committee and also the Committee on Public Laws of the Society, sought without success to have Medical Society representation on the Commission.

Your Committee on Industrial Health notified the Commission that it would like to meet with it, and on October 10, 1947, we were notified that we might have such a meeting, in private session, the first or second week in November, 1947. Ten days later the Chairman of the Commission notified your Committee that a misunderstanding had arisen as a result of an oversight on his part, and that the Society was now invited to testify publicly at a hearing on October 27, 1947. Under the circumstances the Committee prepared a report which

was read to the Commission at the hearing and which is published in full in the RHODE ISLAND MEDICAL JOURNAL in the November, 1947, issue. As noted above, the only complaints placed before this Committee have been those relative to fees. Therefore, the Committee rightfully answered that question in the statement to the Commission. Our statement also carefully noted that it was a Committee report offered to aid the Commission, and that the Society would undoubtedly desire to amplify the statement with recommendations for the improvement of the Workmen's Compensation program as regards all its medical phases.

It is unfortunate that the Commission required a public hearing since the Committee therefore had to prepare a statement on the major complaint of which it had been informed by the Chief of the Workmen's Compensation Division and the insurance companies. Had the Commission permitted an informal conference on all the medical phases of the program, pointing out what its study had shown to be faults, or reporting criticisms, then the Committee, in the light of its experience, might have rendered far more valuable service in the exploration of the ways in which to improve the Act. Authorities whose familiarity with the Rhode Island program was in the main statistical, were allowed to draw freely upon unfavorable experiences in other states regarding medical phases of the Workmen's Compensation Act that were not relevant to the situation here in Rhode Island. Consequently, the medical profession has been publicly subjected to editorial comment in the *Providence Journal-Bulletin* within the month that is without factual foundation and thereby does a great injustice to the physicians in Rhode Island.

The Committee feels that the Society should contribute in every possible way to the strengthening of the Workmen's Compensation Act—but should in no measure yield in its stand that the best care possible of the injured worker is the paramount issue.

The following recommendations are offered by the Committee for consideration by the House of Delegates:

1. That the Rhode Island Medical Society offer to submit to the Workmen's Compensation

continued on page 132

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BIBLIOGRAPHY: (1) Dunn, C. W., in discussion on Werner, A. A.: J. A. M. A. 127:705, 1945. (2) Dunn, C. W.: Pennsylvania M. J. 45:362, 1942.

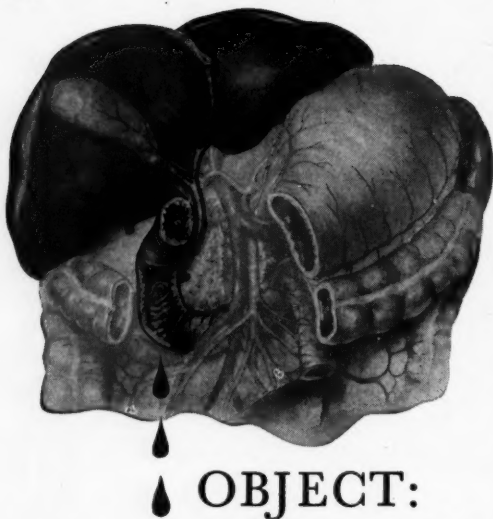
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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.



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RHODE ISLAND MEDICAL JOURNAL

WORKMEN'S COMPENSATION LAW

continued from page 130

Agency a list of 75 physicians to be selected by the Society with due regard for the specialties hereinafter named, and that from this list the Workmen's Compensation Agency select as follows:

3 from each of the following specialty groups:

Dermatology	Neuro-psychiatry
Ear, Nose Throat	Neuro-surgery
Eye	Orthopedics
Gynecology	Radiology
Industrial Medicine	Surgery
Internal Medicine	Urology

1 from each of the following specialty groups:

Allergy	Gastroenterology
Cardiology	Obstetrics
Chest diseases	Pathology
Communicable diseases	

and 7 general practitioners.

2. That this list of 50 physicians to be selected from the master list of 75 physicians submitted by the Rhode Island Medical Society be utilized by the Workmen's Compensation Agency as follows:

- A. As the impartial Examiners for the Agency. Physicians to be used individually, or in groups of three or more.
- B. As personnel for Advisory Boards. Three or more physicians to be selected, with due reference to the specialty care involved, to act at any time on any contested or difficult case coming under the jurisdiction of the agency. It is also recommended that in view of the present situation which provides for compensation for specific injuries by definite added weekly payments or by percentage disability, the Advisory Board be consulted where a reasonable doubt exists as to the fairness of compensation, being allowed to recommend suitable increase in these unusual cases.
- C. As personnel for boards of review. The Advisory Boards above mentioned would alone have the authority of review of the medical status of any case and would also have the authority to recommend a change of physician if in their opinion the patient would be better served thereby.

3. That the prevailing rates for medical care be continued, this to include the physicians fees, dental fees, hospital charges, with related personnel and institutional care, and appliance charges.

4. That the occupational disease and personal injuries be better defined in the law, thereby confining compensation payments to those disabilities clearly arising out of and in the course of employment, or peculiar to a particular type of employment.

5. That the Curative Center be made available to physicians for their private patients, other than workmen's compensation cases, and to various social service agencies, on the recommendation of a physician, who are limited in their present scope of personnel and equipment, provided payment is made by such persons or agencies at prevailing rates established by the Curative Center. It is also recommended that the Division of Vocational Rehabilitation and Physical Restoration of the state department of Education share in the cost of use and operation of the Curative Center.

6. That asbestosis and silicosis be eliminated from special consideration in the law, and that they be included with the other occupational diseases.

7. That no changes be made in the present law which includes no differential in compensation costs or payments for dangerous and non-dangerous trades.

8. That consideration be given to the inclusion under the law of government employees, agricultural workers, employees of public utilities, and domestic workers.

9. That more specific reporting following more accurate and careful examination of back injuries be carried out. To achieve this reporting it is recommended that the Workmen's Compensation Agency issue to each physician in the state special report forms covering specific tests to be done in the treatment of a back injury; and further, that it be required that these forms be returned promptly and completely filled out with information giving the results of such tests on examination. It is also recommended that Medical Advisory Boards, as proposed above, be used for counsel and advice on back injury cases.

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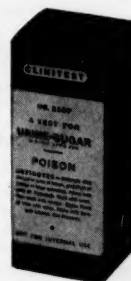
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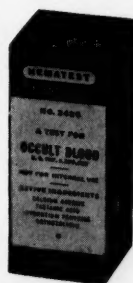
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EIGHTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

At Cleveland, Ohio, January 5-6, 1948

STANLEY SPRAGUE, M.D.

Chairman, Committee on Industrial Health, R. I. Medical Society

THE MONDAY SESSION of the Eighth Annual Congress on Industrial Health opened promptly at 10 a.m. with the report of the Secretary of the Council on Industrial Health, Dr. Carl M. Peterson of Chicago. His talk was short and to the point, bringing out several items which the Council is at present interested in. The two main principles introduced were the approval of residencies in occupational medicine and secondly, the going over of the revisions of the medical advisory board for the miners groups.

Dr. Arthur J. Vorwald from Saranac Lake, New York, spoke on "Essential Correlations Between Medicine and Industrial Research." His paper was largely didactic and the practical suggestions were very few.

A panel followed this at which Dr. A. J. Lanza presided. Three speakers were given the subject "Health and Welfare in the Ladies' Garment Industry."

Mr. Max Meyer of New York, a member of the New York State Industrial Council, may have intended to speak on the subject of History, but his paper dealt entirely with the socialization of medicine, which he definitely urged.

The two following speakers held very little to their points which were to have been "Present Scope and Procedure," and "Medical and Health Implications." These papers were not heard in their entirety as neither speaker seemed to have any practical solution as was expected.

Monday afternoon Dr. Kenneth C. Peacock, of New York, Chairman of the Committee on Industrial Health for the Medical Society of the County of New York, repeated a paper heard early in 1947 and laid out tentative plans for small plant medical services in and around New York. It was apparent, since I heard him in early May of 1947 that many steps toward the carrying out and instituting of medical services had been installed in many small business plants in New York City.

One of the most colorful, brief and yet pungent talks was given by Dr. Harold M. Harrison, of Toronto, who is Medical Director of George Wes-

ton, Ltd., who are packagers and preparers of cooked foods. He really got down to bedrock in treating people as human beings, using a good deal of the so-called old-fashioned psychology which consisted mostly of treating the particular case in hand and accentuating good pats on the back and positive psychology. He was quite amusing in some of his remarks.

The panel which followed this, "How Good Should Industrial Medical Examinations Be?", was probably the most constructive and practical of all the papers heard during this conference. Dr. James R. Miller, of Chicago, who is the Dean of Northwestern University Medical School, was the moderator and he introduced as the discussion leaders Dr. Oscar A. Sander of Milwaukee, an industrial medical consultant, Dr. George H. Gehrmann, of Wilmington, Delaware, medical director of the E. I. du Pont Company, and Dr. William A. Sawyer, of Rochester, medical director of the Eastman Kodak Company.

Each and every one of these speakers stressed physical examinations before employment and stressed the need for medical men to know the jobs for which the particular men were to be employed and said that disabilities should be taken into account and looked at almost entirely from an ability standpoint, rather than to pass every man if he were nearly physically fit and hope for the best. The chest x-ray was accentuated, the blood test was given some consideration, but in the main, the general physical ability of the individual to do the specific job was stressed.

On Monday evening at 6:30 the annual dinner was attended very largely. It was my pleasure to be seated with Dr. Herman A. Lawson, our Rhode Island delegate.

The first speaker of the evening was Mr. Black, who is the President of the Liberty Mutual Insurance Company of Boston. He pointed out the value of getting legislation which would integrate the medical men, the insurer, the employer, and the labor angles and look for greater benefits outside of employment such as hospitalization and so forth

continued on page 136

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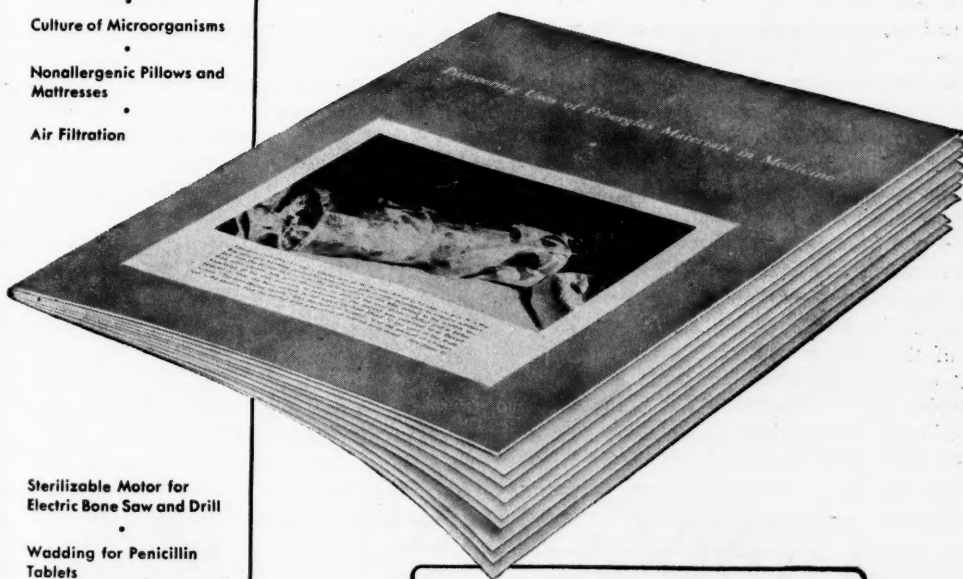
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INDUSTRIAL HEALTH CONGRESS

continued from page 134

for families of the workers, a less insistent attitude on increased benefits by union leaders, a greater interest by more physicians in the various problems of industrial health and accident prevention, and he further stressed the cooperative attitude which he felt insurance companies must have in protecting employers as well as employees either in accident or in health conditions.

Dr. Howard A. Rusk, of New York, who is chairman of the department of rehabilitation in medicine in the New York University College of Medicine, gave a most dramatic and factful address on exactly what was being done in rehabilitation of all types of patients. He presented one man as an example, and this man's speech, though brief, was very effective and was well received by the gathering. He was originally a lawyer in Missouri and was stricken with polio, was totally paralyzed below the waist and 80 percent paralyzed in both arms, and yet today he has been able to overcome a great deal of his upper body paralysis so that he may do many practical things for his own welfare, and it was stated that this man had been given a new position in New York as a lawyer with a firm of well-known lawyers and here he has full charge of legal matters pertaining to the oil companies.

The last speaker of the evening was the assistant medical director of the Eastman Kodak Company who was with the "Operations Crossroads." He described the use of the camera in the taking of all the beautiful pictures which he later showed for this operation which took place at Bikini.

On Tuesday morning at nine there was a conference on respiratory infections. Dr. M. V. Veldee, of the biologic control laboratory, National Institute of Health, spoke on "Virus Vaccines — A Review and Evaluation." The impression remained with me that there is very little definitely known so far about how far these virus infections

can be controlled by any present commercial vaccine. It was pointed out during discussion afterward that the type of influenza germ recently the cause of an epidemic in Los Angeles was a slightly different type than any so far contained in any of the present vaccines.

Several of the audience tried to get him to definitely give an opinion as to whether or not people should be inoculated now, or if not now, when, to protect them from influenza conditions. The answers received were very vague and left it up to the individual doctor to do as he saw fit.

The second speaker was Dr. Alvan L. Barach, of New York, associate professor of clinical medicine, College of Physicians and Surgeons, Columbia University. He gave a very definite talk on "Aerosol Therapy in General and in Industrial Practice." He illustrated with slides of varying types of inhaling apparatus that are being sponsored at Columbia and spoke very favorably of the action of Aerosol with or without penicillin taken orally or intramuscularly in the treatment of many deep-seated, acute and chronic sinuses and bronchial conditions. His paper was very well received and many questions were afterward discussed.

At eleven o'clock Tuesday morning the conference on the outlook for industrial medical service met under the leadership of Dr. Paul B. Magnuson, of Washington, D. C., who is the acting assistant medical director for professional services of the Veterans Administration.

The first speaker was the President-Elect of the American Medical Association, Dr. R. L. Sensenich. He generalized on the subject of industrial medicine and industrial physicians and his closing remarks were that the best physician for everyone concerned at the present time is the family physician.

Dr. Herman G. Weiskotten, of Syracuse, Chairman of the Council on Medical Education and Hospitals of the American Medical Association, gave a rather rambling and legislative talk on making a specialty of industrial medicine as one of the group of specialties recognized by the A M A. It was apparent from his talk that no great amount of attention was to be paid to this practice as a specialty for a long while to come because of the variance of the types of industry in which different doctors were employed.

Dr. James R. McVay, of Kansas City, Missouri, Chairman of the Council on Medical Service of the American Medical Association, followed him with a discussion of what the A M A medical services are and might be.

Tuesday afternoon I anticipated an excellent conference on occupational cancer. Dr. Shields Warren, of Boston, presided and spoke of many

continued on page 138

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*Based on average reported values for milk.

INDUSTRIAL HEALTH CONGRESS

continued from page 136

of the pathologic aspects which occupational cancer takes. His talk was brief and he introduced Dr. William T. Salter, of New Haven, who spoke on "Clinical Aspects." This paper lasted a full hour and was a masterful discussion of organic chemistry. Its application for practical purposes was nil.

Dr. W. C. Heuper, of New York, followed with the clinical aspects. This paper I regret to say I was unable to stay for due to train schedules. It will, however, be published.

In making this report I would call attention to the fact that there were a tremendous number of doctors present at this conference. The ballroom used for the first meeting was well over half filled and the group broke up into varying rooms for the different subjects.

The Committee on Arrangements was most definitely courteous and obliging. The scientific as well as the commercial exhibits were very fine. I do feel that Dr. Peterson as Secretary of the A M A Council on Industrial Health deserves a word of extreme commendation for his arrangements. It is also felt that the fact that the A M A House of Delegates met at the Hotel Statler had a

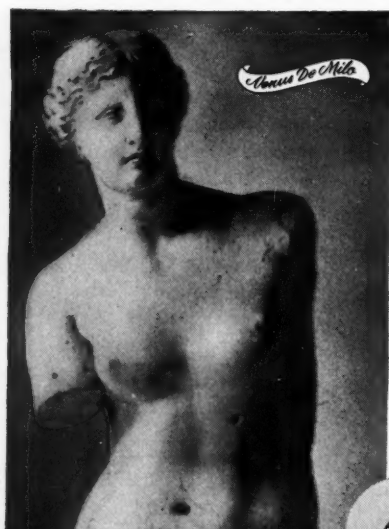
RHODE ISLAND MEDICAL JOURNAL

beneficial action on the presence of such a large number.

There were several papers which could not be heard due to the concomitant recital. Particularly would I like to have heard "The Physiology of the Bone Marrow in Relation to Industrial Intoxication." I would like to have heard some of the papers on nutrition, and certainly I regret missing the paper, "Correlating Rehabilitation and Industrial Practice."

In all, the conference was extremely interesting and while I do not feel that too much of the practical was heard, there certainly was a sufficiency of theoretic and didactic materials presented and it is probable that your delegate did not entirely appreciate their value.

Very little was mentioned about Workmen's Compensation, and the personal touch such as was exhibited in Boston last year was entirely missing. Dr. Hennessey, the assistant to Dr. Peterson, was very cordial and he was very much interested in the new surgical plan suggested by the Rhode Island House of Delegates and was very much interested to hear about the action of the Rhode Island Industrial Health Committee in their suggestions to the Rhode Island Workmen's Compensation Commission.



Abusus De Mito

*Estrogen
Progesterone*
SOLUTION
BREON

double deficiency

"Predisposed to Abortion" describes women who habitually abort because of ovarian hormonal deficiencies. Most spontaneous abortions are preceded by low estrogen and pregnandiol levels indicating that the corpus luteum or chorioplacental system is not producing enough estrogen and progesterone to maintain pregnancy.¹ Often in cases of this kind the woman can become a mother if Estrogen-Progesterone Solution is used to correct the DOUBLE DEFICIENCY. Estrogen-Progesterone is also useful in rapid treatment of secondary amenorrhea.² (Zondek technique.)

Estrogen-Progesterone Solution contains per cc. of oil: 20,000 I. U. Natural Estrogens, 10 mg. Progesterone.

SUPPLIED IN 5 cc. VIALS

1. Vaux, H. W., and Rakoff, A. E.: *Am. J. Obst. & Gynec.*, 50:353, Oct. 1945.
2. Zondek, B.: *J.A.M.A.*, 118:705, Feb. 28, 1942.

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- 1** Fewer Injections
- 2** Simultaneous Immunization
- 3** More Rapid Protection
- 4** Time Saved
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SUPPLIED:

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Five Immunizations package contains three 2½ cc. Vials

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ALUM PRECIPITATED,
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PROVIDENCE MEDICAL ASSOCIATION

Report of 101st Annual Meeting

THE one hundred and first annual meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 5, 1948. The meeting was called to order by the President, Dr. Guy W. Wells, at 8:30 p.m.

The reading of the minutes of the previous meeting of the association was omitted.

Dr. Daniel V. Troppoli read the annual report of the secretary for 1947. It was moved, seconded and passed that the annual report of the secretary be accepted and placed on file.

Dr. J. Murray Beardsley read the annual report of the treasurer for 1947. It was moved, seconded and passed that the annual report of the treasurer be accepted and placed on file.

Dr. Guy W. Wells delivered his presidential address, in which he reviewed the development of medical science in the past century and also discussed the development of early medical societies, referring particularly to the sound origin and development of the Providence Medical Association.

The President called for the nominations for officers for 1948. Dr. Daniel V. Troppoli read the slate of nominees proposed by the Executive Committee which read as follows:

President: Philip Batchelder, M.D.
Vice President: George W. Waterman, M.D.
Secretary: Daniel V. Troppoli, M.D.
Treasurer: J. Murray Beardsley, M.D.

Executive Committee..... } Guy W. Wells, M.D.
 } Herman A. Lawson, M.D.
 (2 members for 3-year terms)

Trustee of R. I. Medical Library..... Frank B. Cutts, M.D.

Delegates:

Robert Baldrige, M.D.	Donald DeNyse, M.D.
Philip Batchelder, M.D.	David Freedman, M.D.
J. Murray Beardsley, M.D.	Peter F. Harrington, M.D.
Alex M. Burgess, M.D.	William A. Horan, M.D.
Peter Pineo Chase, M.D.	Russell R. Hunt, M.D.
B. Earl Clarke, M.D.	Albert H. Jackvony, M.D.
Paul C. Cook, M.D.	Walter S. Jones, M.D.
G. Edward Crane, M.D.	Louis I. Kramer, M.D.
Frank B. Cutts, M.D.	Herman A. Lawson, M.D.
William P. Davis, M.D.	Edward A. McLaughlin, M.D.
John C. Myrick, M.D.	Daniel V. Troppoli, M.D.
Michael J. O'Connor, M.D.	George W. Waterman, M.D.
Edwin B. O'Reilly, M.D.	Frederick A. Webster, M.D.
Patrick I. O'Rourke, M.D.	Guy W. Wells, M.D.

He reported that no counternominations had been submitted to him. It was moved, seconded and unanimously passed that the slate of nominees

submitted by the Executive Committee be deemed official as the officers of the association for 1948.

Dr. Guy W. Wells nominated a committee of Dr. George W. Waterman and Dr. Edward S. Cameron to escort the new President, Dr. Philip Batchelder, to the rostrum.

Dr. Batchelder expressed his appreciation to the members for the honor bestowed on him and he asked the support and assistance of every member in the promotion of the interests of the association during 1948. He also expressed the hope that it will be possible to re-establish the custom of presenting a case report at the beginning of each of the season's meetings of the association.

Dr. Batchelder reported that the roster of committees to serve during 1948 will be published in the RHODE ISLAND MEDICAL JOURNAL. He also

continued on page 142



PHILIP BATCHELDER, M.D.

President, 1948

The Providence Medical Association

44...

OF NEMBUTAL'S CLINICAL USES

SEDATIVE

Cardiovascular

Hypertension¹
Coronary disease¹
Angina¹
Decompensation
Peripheral vascular disease

Endocrine Disturbances

Hyperthyroid
Menopause—female, male

Nausea and Vomiting

Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders

Cardiospasm²
Pylorospasm²
Spasm of biliary tract³
Spasm of colon³
Peptic ulcer³
Colitis²
Biliary dyskinesia

Allergic Disorders

Irritability
To combat stimulation of
ephedrine alone, etc.^{1,1}

Irritability Associated With Infections¹

Restlessness and Irritability With Pain^{2,4}

Central Nervous System

Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant

Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC

Induction of Sleep

OBSTETRICAL

Nausea and Vomiting
Eclampsia
Amnesia and Analgesia⁶

SURGICAL

Preoperative Sedation

Basal Anesthesia

Postoperative Sedation

PEDIATRIC

Sedation for:

Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization
procedures
Minor surgery

Preoperative Sedation

Nembutal alone or ¹Glucophyl-
line[®] and Nembutal, ²Nembutal
and Belladonna, ³Ephedrine and
Nembutal, ⁴Nembudeine[®],
⁵Nembutal and Aspirin, ⁶with
scopolamine or other drugs.



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PROVIDENCE MEDICAL ASSOCIATION MEETING

continued from page 140

announced that the annual reports for 1947 would be published in the medical journal and therefore would not be read at the meeting.

Dr. Troppoli reported for the Executive Committee as follows:

The Executive Committee has approved of the budget for the operation of the association during 1948 of \$6,827. To meet this budget the committee recommends that the annual assessment for 1948 be \$15 for active members and \$5 for associate members.

A motion was made from the floor, seconded and passed that the budget as reported be accepted and that the annual assessment as proposed be established for 1948.

The secretary reported that the Executive Committee recommends for election to active membership in the association William C. Howrie, Jr., M.D., of 252 George Street, Providence.

It was moved, seconded and unanimously passed that Dr. Howrie be elected to active membership.

The President made the following announcements:

1. Within the next ten days the members of the association will receive a notice of the Centennial Day observance, to be held on Saturday, January 31. There will be an address at the medical library at 4:30 p.m., by Dr. Reginald Fitz of Boston on the history of the association. Afterwards a social hour, to be followed by dinner, will be held at the Sheraton-Biltmore Hotel. Members are urged to acknowledge the invitation for reservations for the dinner promptly.

2. On Monday, February 2, the association will meet jointly with the Rhode Island Medical Society. The two topics chosen for discussion at this meeting are: "Hospital Economic Problems with Special Reference to Intern, Resident and Staff Appointments," and "The Position of the General Practitioner Today."

Outstanding guest speakers will address the members on both subjects.

The business meeting completed, Dr. Batchelder introduced the speaker of the evening, Dr. Samuel Levine of Boston, who spoke on the topic "Extra-Mural and Intra-Mural Practice, Then and Now."

Dr. Levine stated that one hundred years ago there was a tremendous difference in the role of the practitioner of medicine as compared to that of today. All he could do could be done in the patient's home and in his office. That is all changed now. "The New England Medical Journal" of 1848 was then called "The Boston Medical and Surgical Journal." Most of the articles at that time were on infectious diseases, midwifery and

accidents. There were many discussions on ether, the new drug of that era.

One interesting article was on the treatment of rattlesnake poisoning. Blistering was used for typhus fever. Different drugs for different pains of dysentery were used. All that was known of medicine was therefore done at home or in the office. There was little use for hospitals except for a place to isolate cases — usually from ships — and an alms house to care for the poor.

What simple things can we do to guide us now in correct diagnoses and treatment? Hospital training, with all its laboratory work and x-rays, is quite different from outside practice. In hospitals diagnoses are automatically made for you by the routine tests. This is a bad habit to get into because you cannot do that kind of thinking when you leave the hospital.

On the outside we have to think of all the diseases ruled out by tests in the hospital in our differential diagnosis. We have to make shortcuts which narrow down the field of the panorama of possibilities of diagnosis. Do the right test first and save the patient time and money. A simple clinical finding that costs nothing and is quick and inexpensive is what you want in diagnosis. That is if a patient can walk briskly in cold weather, he does not have angina pectoris — if the pale patient has a furred tongue, he does not have pernicious anemia. Also, a patient with cardiac enlargement cannot have Addison's Disease.

In making these inexpensive diagnosis, we keep open the hospital beds for those more urgently in need of them. We need the hospital when we can't make a diagnosis with our simple methods used intelligently. However, the better we employ the simple methods extramurally, the less we need the hospital. Any sacrifice is indicated when you are looking for something you could cure.

We should keep asking ourselves what can we do to be helpful, what are we overlooking that can be helped.

It is more important to think of rare diseases that are curable than common diseases that are not curable. The responsibility of the physician today is tremendous as compared to the ones of one hundred years ago.

The meeting adjourned at 10:15 p.m.

Attendance 116.

Collation was served.

Respectfully submitted,

DANIEL V. TROPOLI, M.D., *Secretary*

NEWPORT COUNTY SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, December 30, 1947.

The meeting was presided over by Dr. Alfred M. Tartaglino, who presented Dr. Jay Rice Moody,

continued on next page

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who in turn showed a group of color motion pictures relating to several of the activities which had taken place under the sponsorship of the Gay Nineties Committee in Newport during the past several years. The pictures included scenes from the parades held on the last two Labor Days, scenes taken during the pilgrimage to Colonial Newport, pictures of the yacht races held in Newport harbor in the lower bay, and photographs of many of the buildings of historic interest in and about Newport.

Following the presentation Dr. Moody was given a rising vote of thanks.

The application of Dr. Eugene Tartaglino for membership in the Society was then received and he was elected to membership.

Dr. Samuel Adelson then discussed the present status of the Prepayment Surgical Plan and stated that several insurance companies are now ready to offer for sale policies which have been approved by the State Medical Society.

Following adjournment a collation was served.

Respectfully submitted,
HENRY W. BROWNELL, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held January 15, 1948,

RHODE ISLAND MEDICAL JOURNAL

at 9:00 p.m. in the Nurses' Auditorium of the Memorial Hospital.

The President, Dr. Earl Mara, called the meeting to order and the minutes of the previous meeting were read by the Secretary. They were accepted as read.

Dr. Mara announced the opening of a new Thoracic Clinic at the Memorial Hospital which would be directed by the speaker of the evening, Dr. Joseph Corsello. Before his main discussion Dr. Corsello spoke briefly about the new clinic, stating that it would not run in competition with the established Tuberculosis Clinics and that the main interest was primarily in non-tuberculosis chest conditions. However, it would function as a pneumothorax refill clinic for Pawtucket and the immediate vicinity.


The topic for the evening was "Diagnosis of Primary Carcinoma of the Lung." Dr. Corsello illustrated his remarks with a series of lantern slides and later answered numerous queries from the floor.

The meeting adjourned at 10:45 p.m. Twenty members attended.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D.
Secretary



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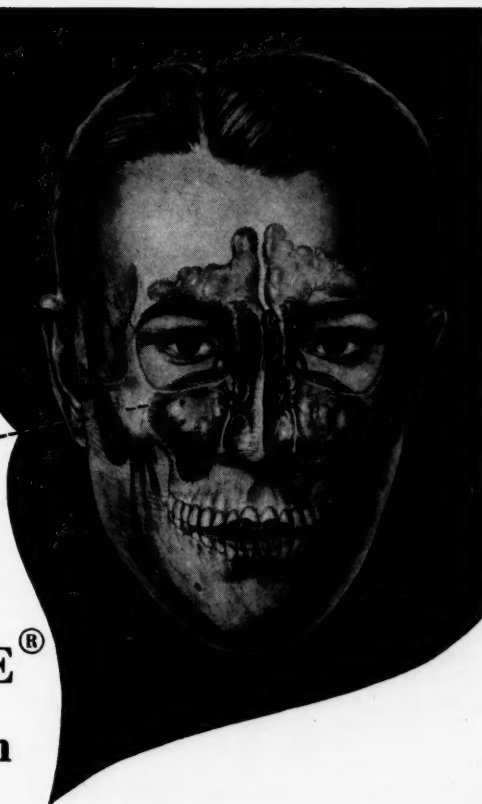
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ANNUAL REPORTS FOR 1947

PROVIDENCE MEDICAL ASSOCIATION

ANNUAL REPORT OF THE SECRETARY — 1947

The Providence Medical Association held eight scientific assemblies during 1947. The February meeting was a joint meeting with the Rhode Island Medical Society. Attendance at the meetings averaged ninety-six members. The topics presented and the speakers of the meetings were as follows:

January 6—Presidential Address. Paul C. Cook, M.D.

"Rhode Island's Water Pollution Problem." Panel discussion conducted by Alex M. Burgess, M.D., "Residency and Fellowship Program at the Rhode Island Hospital," Charles L. York, M.D., Herbert F. Hager, M.D., Michael DiMaio, M.D., Wilbur Mantner, M.D. and William J. H. Fischer, M.D., participating.

February 3—"The Role of the General Practitioner in the Early Diagnosis of Pelvic Cancer." Lewis C. Schefey, M.D., of Philadelphia. "The Diagnosis and Treatment of Liver Disease, with Special Reference to Liver Biopsies." Chester M. Jones, M.D., of Boston.

March 3—"Certain Phases of Water-Borne Infections." Charles A. Stuart, Ph.D., Professor of Biology, Brown University. "Water Pollution Control." Arthur D. Weston, of Boston.

April 7—"Hormonal Alteration of Carcinoma of the Breast." Ira T. Nathanson, M.D. "Lymphatic Spread of Carcinoma and Its Management." Grantley Walder Taylor, M.D., of Boston.

May 5—"The Newer Knowledge of Viruses." Raymond M. Young, Ph.D., Bacteriologist at Rhode Island Hospital. "Clinical Aspects of Certain Functional Disorders of the Biliary Tract," Russell S. Bray, M.D.

October 6—"The German Medical War Crimes." Cortez F. Enloe, Jr., M.D., of New York City.

November 3—"The Characteristics of Asthma in Infancy." William P. Buffum, M.D. Discussant, Stanley Freedman, M.D. "Pathology of Allergic Reaction to Sulfonamides in a Child." Melbourne Brunett, M.D., Robert J. Williams, M.D.

December 1—"The Use of a Low Sodium Diet in Hypertension and Congestive Heart Failure." Michael DiMaio, M.D. "Carcinoma of the Cervix its Prophylaxis Early Diagnosis and Treatment." George Waterman, M.D.

The total members of the Association at the end of the year was 591, of whom 550 are active members and 41 are associate members. At five meetings of the Executive Committee held during the year, a total of fifteen physicians were recommended for election to active membership, eight were granted leaves of absence for postgraduate work, three resignations were accepted of men moving out of the state, one member returning to Providence was reinstated, and fourteen members were approved for associate members.

During the year the following members of the Association died:

Hampartzum S. Gulesserian (January 3)

Harlan P. Abbott (February 2)
Bertram H. Buxton (February 9)
Salvatore Castallo (March 18)
Charles M. Collins (May 9)
Victor P. Rego (June 25)
Jay Perkins (October 18)
William H. McLaughlin (December 7)
George V. Coleman (December 10)

Among the most important actions taken by the Executive Committee during the year was the revival of the house officers Prize Case Report Contest, the development of plans for the Centennial observance of the Association, a study of fees paid by insurance companies for the examination of subscribers, a study of the parking adjacent to physicians offices in the east side area, recommendation of legislation for better sanitation in eating establishments in the city, a study of the free day of the members for the purpose of compiling lists to aid the public, endorsement of the state medical society's prepaid surgical insurance program, and support of the essay contest of the American Association of Physicians and Surgeons.

In 1947 the Rhode Island Medical Society approved of the formation of the Bristol County Medical Society as a district unit. Previously the Bristol County physicians had been affiliated with our Association. It is with pleasure that we report that the majority of these physicians have accepted Associate membership with the Providence Medical Association.

Respectfully submitted,

DANIEL V. TROPOLI, M.D., *Secretary*

January 5, 1948

ANNUAL REPORT OF THE TREASURER, 1947

RECEIPTS:

Cash on hand, January 1, 1947.....	\$ 664.00	
Membership dues (including 1946 outstanding assessments and two 1948 payments)	7,566.86	
Dividends from investments	22.50	
Annual dinner payments	20.00	
Total		\$8,273.81
Receipts	\$8,273.81	
Expenses	7,177.09	

Cash Balance (Jan. 1, 1948).....	1,096.72
U. S. War Bonds.....	2,740.00

Total Assets, Jan. 1, 1948 \$8,336.72

EXPENDITURES:

Committees	\$ 150.00
Collations	467.50
Journals (new, and binding of old)	501.10
Meetings expenses	81.17
General expenses	954.30
Postage	107.94

Printing	280.45
Supplies and equipment	105.64
Refunds (Bristol County members, and Entertainment Committee)	80.00
R. I. Medical Society (Appropriations)	2,148.08
(Use of Library, etc.)	
Salary	1,684.80
Taxes (withholding and social security)	437.76
Telephone	178.35
Total	\$7,177.09

J. MURRAY BEARDSLEY, M.D., *Treasurer*

January 5, 1948

AIR POLLUTION

A new City ordinance for Air Pollution Regulation was approved by the City Council on January 17, 1947. A new air pollution regulation engineer and three assistants within the Department of the Public Service Engineer have been appointed as required by the ordinance. Also, as required, an Advisory Board and an Appeal Board of five members each, have been appointed. The law requires that at least one Doctor of Medicine be included in the membership of each board. Dr. E. S. Cameron and Dr. B. E. Clarke have been made members of the Advisory and Appeal Boards respectively. Members of these two boards receive no remuneration.

The City of Providence now has a good modern Air Pollution Ordinance, but conditions to date are not quite so ideal in Providence as pictured in an article appearing in the September issue of the American City Magazine. We may expect further improvement in the near future as

the new appointees within the Department of Public Service become more familiar with the work. Because of the present oil shortage more coal is being burned and this makes the control of air pollution by smoke more difficult.

Members of this association may secure copies of the New Ordinance on Air Pollution Regulation by phoning or writing City Hall. Those who observe persistent violations may help the cause by reporting such violations to Mr. Joseph M. Santoro, Air Pollution Regulation Engineer. The problem involves all of us.

Respectfully submitted,

EDWARD S. CAMERON, M.D., *Chairman*

FRANK M. ADAMS, M.D.

ALEX M. BURGESS, M.D.

B. EARL CLARKE, M.D.

ANTHONY CORVESE, M.D.

**ADVISORY COMMITTEE TO THE
COMMUNITY WORKSHOPS**

During 1947 there has been one meeting of the full committee at which matters of importance to the Community Workshops were discussed and recommendations made. The Executive Committee of the Community Workshops has consulted the chairman of your committee on occasion, and members of your committee have assisted the Community Workshops in a number of matters which did not require concerted action.

CLIFTON B. LEECH, M.D., *Chairman*

RAYMOND F. HACKING, M.D.

WILLIAM A. HORAN, M.D.

LOUIS B. SAGE, M.D.

NATHAN A. BOLOTOW, M.D.

CATHERINE ZOURABOFF, M.D.

JOHN LANGDON, M.D.

*continued on page 149**For your protection . . .***Prescribe Certified Milk A Standard of Excellence****PURE • NUTRITIOUS • SAFE****Certified Milk****IN RHODE ISLAND IS****PRODUCED BY****Cherry Hill Farm****Fairoaks Farm****Hampshire Hills Farm****Walker-Gordon Lab. Co., Inc.****DISTRIBUTED BY****H. P. Hood Co.****Fairoaks Farm****Whiting Milk Co.****H. P. Hood Co.****Whiting Milk Co.****DE 3024****PE 6870****CA 5363****DE 3024****GA 5363****Certified Milk Deserves Your Recommendation**

REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION

1947

CERTIFIED MILK in Providence during 1947 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fair-oaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and *Brucella abortus* infections.

Much credit is due the management of these farms in keeping the standards of Certified milk on a high plane and these high ideals have been realized in spite of the acute shortages in materials and labor.

On August 19, 1946, the City Council of Providence approved two additional rules governing the sale of milk in Providence. Rule 12 applies to the sale of raw milk which has a bacteria count of less than 10,000 colonies per cubic centimeter as an average bacteria count of any four consecutive samples examined by the Inspector of Milk using methods set forth in the current edition of "Standard Methods of Milk Analysis" of the

American Public Health Association, and unless such raw milk be produced from cows that are certified to be free from Bang's Disease, Tuberculosis and Mastitis by a licensed Veterinarian at such intervals as the Inspector of Milk shall deem necessary for the protection of the milk consuming public.

The above standards are those set forth in "Methods and Standards" published by the American Association of Medical Milk Commissions and these requirements are enforced by this Commission. We are happy to say that all raw Certified Milk sold in this area for many years has met these requirements and much credit is due to the Certified Farms in meeting these rigid tests.

During the past year the Commission has carried one-half page advertisements in the R. I. MEDICAL JOURNAL in an attempt to keep the "Quality Milk" before the medical profession.

The Commission is indebted to Professors Wilson and Stuart of Brown University for their continued cooperation in supervising our laboratory work at Brown University.

HAROLD G. CALDER, M.D., *Chairman*

THOMAS J. DOLAN, M.D.

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WILLIAM P. SHIELDS, M.D.

HENRY E. UTTER, M.D.

GEORGE E. BOWLES, M.D.

REUBEN C. BATES, M.D., *Secretary*

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1947

	CHERRY HILL H. P. HOOD			FAIROAKS						HAMPSHIRE HILLS			WALKER- GORDON		
	Pasteurized			Raw			Pasteurized			Pasteurized			Vit. D. Pasteurized		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.9	12.35	39	4.2	12.95	5,172	3.9	12.56	80	4.1	12.66	149	3.9	12.59	44
February	3.8	12.17	44	4.1	13.00	4,478	3.8	12.55	231	4.1	12.70	185	3.9	12.58	134
March	3.8	12.15	72	4.1	12.92	4,356	3.7	12.37	156	4.3	12.81	181	4.0	12.73	109
April	3.9	12.31	78	3.9	12.38	4,666	3.8	12.39	113	4.3	12.96	195	3.9	12.56	164
May	3.9	12.42	30	4.1	12.96	5,388	3.8	12.62	133	4.1	12.63	82	3.9	12.63	149
June	3.8	12.32	33	4.2	12.85	8,735	3.9	12.59	44	3.8	12.39	43	3.8	12.38	160
July	3.8	12.33	49	4.3	12.70	18,033	3.9	12.45	116	3.8	12.59	111	3.9	12.50	121
August	3.9	12.58	53	4.2	13.07	5,290	4.1	12.84	352	3.9	12.66	85	3.9	12.39	65
September	4.1	12.74	96	4.2	13.00	5,122	3.8	12.20	281	3.9	12.73	161	4.1	12.62	87
October	4.0	12.62	28	3.9	12.42	4,011	3.8	12.29	98	4.1	12.70	51	4.1	12.64	35
November	4.1	12.52	25	4.0	12.75	3,614	3.8	12.40	128	4.2	12.97	65	3.9	12.46	27
December	4.0	12.69	31	4.4	13.32	2,725	3.9	12.64	27	4.3	13.27	34	4.0	12.65	18
Yearly Average	3.9	12.43	47	4.1	12.86	5,965	3.8	12.49	146	4.0	12.75	112	3.9	12.56	93

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ENTERTAINMENT

The Committee on Entertainment has arranged and provided for the collation following each regular meeting of the Association. It is particularly grateful to our executive secretary, Mr. John E. Farrell, for attending to the details of this function.

It is happy to report that the annual dinner and golf tournament was held at the Agawam Hunt on Wednesday, September 17, 1947. A record attendance of members and their guests was registered at the links as well as at the dinner. The President's Cup was awarded by our president, Dr. Guy W. Wells, to Dr. William J. H. Fischer, Jr., for low net score in the Bankers' tournament.

Many members who attended the dinner were recipients of valuable and attractive door prizes. The performance of a professional entertainer was received with considerable enthusiasm and enjoyment. All comment received by your committee was most favorable.

HERMAN P. GROSSMAN, M.D., *Chairman*

NATHAN BOLOTOW, M.D.

RALPH DI LEONE, M.D.

CARL D. SAWYER, M.D.

LEGISLATION

Early in 1947, the chairman of your committee and Mr. Farrell met with Mayor Roberts to express our interest in matters concerning medicine and health. Through his cooperation and that of the City Clerk, Mr. Whelan, we have been kept informed regarding any contemplated city legislation which pertains to medicine or public health.

The subject in which we have been chiefly interested has been the matter of restaurant sanitation, and considerable data on this subject was gathered through correspondence with various public health authorities. A model ordinance was obtained and presented to the committee of the Providence City Council appointed to consider the problem of restaurant sanitation. This committee approved and recommended the ordinance we presented. We also met with members of the Rhode Island Restaurant Association and discussed the proposed ordinance with them.

We have subsequently learned, however, that the licensing of restaurants is in the hands of the Bureau of Police and Fire, and therefore the proposed ordinance would be invalid and impossible to enforce. It is proposed that at the next meeting of the General Assembly, the City Solicitor will request the passage of a law which will invest the power of supervising and regulating restaurants in the Superintendent of Health, and, following this, the model

ordinance proposed can be rationally passed by the City Council. We hope to be able to follow this procedure through to its desired conclusion.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Chairman*

ALBERT H. JACKVONY, M.D.

HENRY S. JOYCE, M.D.

ANTHONY V. MIGLIACCIO, M.D.

JAMES H. FAGAN, M.D.

PRE-SCHOOL EXAMINATIONS

The Rhode Island Congress of Parents and Teachers continues its efforts to conduct an effective pre-school examination as part of its health program according to Mrs. Kenneth A. Scott, Health and Summer Round-Up Chairman. The final reports from the various units have been tabulated and there will be an evaluation of the results. The figures for 1947 in both the number of children examined and number of units participating are lower than in 1946.

Providence made a rather elaborate effort on summer round-up in the spring of 1946. Meetings were held which were addressed by principals and others. They were advertised to parents but the results were disappointing. This spring members of the Parent-Teacher Associations were provided with names and addresses of the potential school entrants. "Each local Kindergarten teacher carries on her own program in which she attempts to interest the mothers of the children in her neighborhood."

"Only 17 units completed the final phase of the Round-Up by returning their report blanks, although 28 units sent in applications. However, we find that although we have only 17 units compared to 30 units a year ago, we have examined just over 100 less children than a year ago. This means that each unit did more work and this year cared for 21 plus children compared to 15 plus children last year. It is interesting to note that approximately three-fourths of all children examined in spring Round-Ups had been vaccinated and immunized against diphtheria.

Our conclusions are therefore as follows: although fewer units conducted a Round-Up each one did do a better job than before, particularly when done as a group Round-Up. These are conducted as examining Round-Ups only and children are referred to their family physician for immunization, vaccination and the correction of any physical defects.

The Parent-Teacher organization is very grateful to the physicians who assisted the Units in their communities in conducting a successful Round-Up and in the various radio talks to publicize health examinations."

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School districts participated as follows: Cranston, Glocester, Jamestown, Portsmouth, Providence, Smithfield, Warwick. No doubt there were others in which examinations were conducted but perhaps not reported. There were a total of 385 children examined.

"An advisory health committee has been formed to assist Mrs. Scott in planning the health activities. The committee includes Miss Elizabeth Smith, Supervisor of Public Assistance in Rhode Island; Dr. Gertrude Muller of the Child Guidance Clinic; Mrs. Frank Collaci, a nurse and health chairman for Providence Council last year; Dr. John Langdon, Providence pediatrician, a Providence dentist; and Dr. John Farrell, Executive Secretary of the Rhode Island Medical Society. From the meeting in November of this committee suggestions were made for more emphasis on an early spring Health Day program in the schools for new mothers to inform them of the need of early pre-school examinations and to prepare the mothers for the adjustments, both mental and physical, which the children will have to make their first year in school."

The Committee of the Association serves mainly as an advisory group on the medical procedures involved in the pre-school round-up. During 1947 it was not necessary to hold any meetings.

Respectfully submitted:

CHARLES B. LEWIS, M.D., *Chairman*
ROBERT M. LORD, M.D.
MERLE M. POTTER, M.D.
MICHAEL J. NESTOR, M.D.
TEMPLE BURLING, M.D.
JOHN T. MONAHAN, M.D.

READING ROOM

Evening Hours: (January 2, 1947 through December 11, 1947)

The Library was open 102 evenings. The total number of visitors was 262. Of these, 98 were physicians. The remaining 164 included students, teachers, nurses, dentists, etc. Evening hours seem to be growing in popularity.

Binding:

One hundred and forty volumes have been bound this year; 1 repaired. Six volumes are at the bindery now.

Journals:

The Association paid for subscriptions to 36 medical journals during 1947—over half of the most widely read specialty journals.

The JOURNAL OF BONE & JOINT SURGERY, for which the Providence Medical Association pays, will be published in two volumes in 1948, one American, one British—thus doubling the number of issues of this important journal.

The first Reading Room Committee of the Providence Medical Association was appointed in May, 1877. It started subscriptions to five British and six American journals. All the journals were presented to the Rhode Island Medical Society in 1880, and the Association has continued to subscribe for journals for the State Society ever since.

Respectfully submitted,

IRVING A. BECK, M.D., *Chairman*

COMMITTEE ON TUBERCULOSIS

Your committee has continued to work on the problems of tuberculosis control. A plan for tuberculosis control in the hospitals of Rhode Island was drawn up and sent to the various hospitals in the State. A copy of this was published in a previous issue of the JOURNAL. A follow-up letter is to be sent annually to these hospitals with a form to be filled out, indicating what procedures are used and what results are obtained.

Because of the shortage of tuberculosis beds and the consequent long waiting lists for patients seeking treatment for tuberculosis, a sub-committee was formed to study conditions at Wallum Lake Sanatorium. It was the hope that they might be able to find some means by which more patients could be handled. After their visit to the Sanatorium, it was felt that everything within reason was being done, that the shortage of beds was a result of difficulty in hiring and keeping personnel at the Sanatorium. It appeared that the only means of immediate improvement would be to cut down the stay of the Sanatorium patients to the minimal period compatible with adequate care.

The Committee is of the opinion that to further promote interest and understanding of tuberculosis problems, it would be advisable for the various county medical societies to appoint tuberculosis committees for the purpose of studying and handling local problems.

The matter of tuberculosis control amongst school teachers has been discussed, and the Committee is of the opinion that it would be advisable to have chest plates of all teachers annually. Further, it would seem advisable to have annual x-rays of all schools employees, especially those who come in close contact with pupils. A definite program for this procedure has not yet been worked out.

The Eastern Section of the American Trudeau Society has been inactive during the War years. The Officers of the Section are interested in carrying out a program that will be helpful to the localities covered by this Section and have requested recommendations from the various states. In discussing this matter, the Committee felt that the Section would serve a more useful purpose if it were not so large, if there were a New England Section to represent this particular region, and that it might combine with other local groups interested in tuberculosis in order to prevent a certain amount of repetition and to provide a more unified program. It was suggested that the Eastern Section might draw up a list of speakers who could be called upon to give talks to local societies on various aspects of tuberculosis. These recommendations will be presented at the forthcoming meeting of the Eastern Section of the American Trudeau Society.

JOHN C. HAM, M.D., *Chairman*
U. E. ZAMBARANO, M.D.
PHILIP BATCHELDER, M.D.
JOHN PINCKNEY, M.D.
PETER F. HARRINGTON, M.D.
FLORENCE M. ROSS, M.D.
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